

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted July 15, 2022

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

RE: CCN: 245290

Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 30, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 30, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

Olivia Restorative Care Center July 15, 2022 Page 2

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 30, 2022 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 30, 2022 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Olivia Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 30, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

Olivia Restorative Care Center July 15, 2022 Page 3

correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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 their 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

Olivia Restorative Care Center July 15, 2022 Page 4 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 30, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

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> Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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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 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,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 15, 2022

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

Re: State Nursing Home Licensing Orders

Event ID: 51XZ11

Dear Administrator:

The above facility was surveyed on June 28, 2022 through June 30, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

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"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

PRINTED: 07/31/2022 FORM APPROVED OMB NO. 0938-0391

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	onsite revisit of you validate that substate regulations has been	azards/Supervision/Devices	F 6	89			7/22/22
	§483.25(d) Accider	nts.					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

Electronically Signed

07/22/2022

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F 689 Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide adequate supervision despite being a known elopement risk, for 1 of 1 residents (R1) who left the facility, self-propelling in a wheelchair with the intent of returning to his home, over a mile away, with an air temperature at 90 degrees Fahrenheit (F). A stranger subsequently picked up R1 a few blocks away from the facility on 6/18/22, the facility failed to place interventions that would prevent recordernece, placing R1 at risk for serious harm, injury, or death if he should elope again. The IJ began on 6/18/22, when the facility failed to place interventions to prevent R1 from eloping again and was identified of n 6/29/22. The administrator and director of nursing (DON), were notified of the IJ on 6/29/22, at 4/28 p.m. The IJ					1003 WEST MAPLE	•	
The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide adequate supervision despite being a known elopement risk, for 1 of 1 residents (R1) who left the facility, self-propelling in a wheelchair with the intent of returning to his home, over a mile away, with an air temperature at 90 degrees Fahrenheit (F). A stranger subsequently picked up R1 a few blocks away from the facility and brought him to R1's home in the community. This resulted in an immediate jeopardy (IJ) for R1 when, after he was returned to the facility on 6/18/22, the facility failed to place interventions that would prevent recocurrence, placing R1 at risk for serious harm, injury, or death if he should elope again. The IJ began on 6/18/22, when the facility failed to place interventions to prevent R1 from eloping again and was identified on 6/29/22. The administrator and director of nursing (DON), were notified of the IJ on 6/29/22, at 4:28 p.m. The IJ	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	the door automatic resident from leave the elopement risk WanderGuard was Discrepancies were documentation on have a WanderGu MDS indicated he Evaluation indicated mention a Wander Physician orders for could go on pass a with responsible at A physician visit not had been less agit be living at the fact out on pass and visit was concerned ab ability to make information indicated, he too, was well. R1 had significated, he too, was well. R1 had significated, he would seek psystatus. A psychiatry note of impulsive and his desire to go home 5/31/22, indicated had short term mention impairment in concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention concerned as a physician desire to go home 5/31/22, indicated had short term mention co	en in the vicinity of an exit door, cally locks preventing the ing unattended). According to a evaluation form, a in use at that time, 4/15/22. The noted in the facility whether R1 had or did not lard in place on 4/15/22. The did not. Elopement Risk and he did. The care plan did not and/or LOA (leave of absence) party and his medication. The dated 4/27/22, indicated R1 and/or LOA (leave of absence) party and his medication. The dated 4/27/22, indicated R1 and understood he would ality long-term. R1 wanted to go asit his wife and children. Family bout his competency and his formed decisions. The physician was very concerned about that guificant behaviors in the past gesturing. The physician noted architection input into his mental dated 4/28/22, indicated R1 was lack of insight extended to his. A psychiatry note dated R1 lacked safety awareness, amory impairment and		89		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ONSTRUCTION	` '	E SURVEY PLETED
		245290	B. WING				C 30/2022
	PROVIDER OR SUPPLIER	CENTER		1003	ET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE /IA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	collections (coins a facility. The physicia really slept and spewheelchair with an recliner. The physic (medication to relie one half hour before the half hour before the half hour before the home in the common wheelchair. The DO advised to call law a return him to the facility member (FM)-C with home in the common wheelchair. The DO advised to call law a return him to the facility member (FM)-C with home in the common wheelchair. The DO advised to call law a return him to the facility member (FM)-C with home in the charge nurse results and left the build gone home. Per the propelled his wheel up by a friend in a prest of the way hom to go home.' 'I didn't DON was called whimmediately call 01 to the home address R1 back to the nurse and oriented. The in were no predisposit active exit seeker. I wanted a young girl told she could not. I home" to get his may witnesses were four witnesses were four the home and the home. The interest of the could not. I home to get his may witnesses were four witnesses were four the home.	and wanting all of his nd marbles) brought to the an was informed that R1 never nt all day and night in his occasional half hour in his tian ordered Ativan ve anxiety) to be administered		89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	` '	E SURVEY IPLETED
		245290	B. WING				C 30/2022
	PROVIDER OR SUPPLIER	CENTER		1003	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE VIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	trained medication on duty when R1 el 3:00 p.m. on 6/18/2 because he wanted him a bath and that According to TMA-RFM-C called the fact p.m. to report R1 w stated they were not building, adding that between his room at telling anyone. TMA-B stated they were not for a bit. TMA-B stated on his wheelchair for removed and she downward and she downward that day are stated she did know had been sitting on needed help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-produced help; R1 as house. FM-C stated help; R1 as	on 6/28/22, at 2:11 p.m. aide (TMA)-B stated she was oped. TMA-B stated at about 2, R1 had been upset a certain employee to give employee could not. 3, the next thing she knew, cility at approximately 4:15 as at her house. TMA-B at aware R1 had left the at R1 had gone out an exit door and the nurses station without A-B did not know if R1 was an ting it was not uncommon for atside in his wheelchair to sit ated R1 had a WanderGuard or a while, but it had been	F 6	889			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		` '	E SURVEY IPLETED
		245290	B. WING				C 30/2022
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 689	he wanted when he look at his marble of thought the time wanted sure. FM-C state since 2/3/22, and he before. When asked on is body or wheel put one on and he comething bad enough. TM-C, she was at the 6/17/22, for beer are he cut off his Wandstated she didn't kn R1 fibs a lot, so she According to websit temperature in the 6/18/22, was 93 degree During an interview DON stated on 6/18 charge nurse called the facility to inform The DON advised senforcement pick he facility. The DON the and social services to talk to staff. Fifte initiated. The DON on Monday 6/20/22 (RC)-D and vice pre (VPCS)-E arrived to included a care conditioned to happen sooner be threaten it all the time of unhappy at the	sing home, that's mainly what came home, he wanted to collection." FM-C stated she is about 6:00 p.m., but was ed R1 had lived at the facility ad not tried to go home dif R1 had an alarm bracelet chair, FM-C stated no, "they cut it off," adding, if R1 wants ugh, he will do it. According to ne facility the evening of it brat night when R1 told her erGuard bracelet. FM-C ow what to believe because a didn't report this to the staff. The ways accuweather.com, the community on the afternoon of		689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	TE SURVEY MPLETED
		245290	B. WING _		06	C / 30/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1003 WEST MAPLE OLIVIA, MN 56277	•	OOILUL
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	talking to R1, the sidellowed out the sidelopement. The DiwanderGuard braunbeknownst to the time, the facility waverification of Warresidents and ther asked if the facility WanderGuard brasince R1 was asseelopement, the DORC-D and VPCS-Epurposeful and this mental status) was cognition), so a Winecessary. The Doinvestigation, RC-lelopement was "ne R1 had a purpose During this interview conversation and sinvestigation that a necessary because purposefully and known for those reasons elopement. During the same in placed a phone can was doing. He for him to leave the own person and him a WanderGuard was adding, "He's a guide He collects stuff and the collects and the collects stuff and the collects and the collects stuff and the collects and the collec	age 7 ON, the investigation included staff and a resident who R1 de door on the day of he ON stated R1 had a celet on until 6/18/22, when e facility, R1 cut it off. At that as not conducting daily nderGuard bracelets on efore it went undetected. When had considered reapplying the celet following the elopement essed at being at risk for ON stated they were told by that R1's elopement was BIMS (brief interview for a 14 (indicating intact anderGuard was not ON stated following their O and VPCS-E concluded the ot a true elopement" because and knew where he was going. When the administrator joined the stated she understood from the at WanderGuard was not e R1 left the facility new where he was going, and it was deemed not an interview, at 4:00 p.m., the DON all to VPCS-E who stated, it an elopement. He knew what planned to leave. It was safe the facility unsupervised - he's his is BIMS is 14." VPCS-E stated as not appropriate for R1, y I would let sign out and go. In the capability to cut and the capability to cut	F 68	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	` /	(X3) DATE SURVEY COMPLETED	
		245290	B. WING		06	C / 30/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1003 WEST MAPLE OLIVIA, MN 56277	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	would not be effect implemented one was more proactive his own person." A R1's behaviors, he why we added implement going outside the facility did not when going outside DON stated Wand at the facility in Applement of Wand and the DON, the placement of Wand after the elopement of wand after the wanderGuard the WanderGuard the wanderGuard the wanderGuard the elopement of wand after the elopem	bage 8 I bracelet off and therefore it ctive. VPCS-E stated the facility to one activities with R1 which we and they educated R1; "He's VPCS-E stated they "Reviewed the rolls away, gets mad, that's coulsiveness to his care plan." It require residents to sign out the to enjoy the weather. Who on 6/28/22, at 5:06 p.m., the derGuard's were implemented oril 2022 when they closed their and a WanderGuard bracelet telchair just prior to a 4/15/22, aluation, but according to the cent date was not documented. The facility was not verifying inderGuard's on residents until incident on 6/18/22. R1 cut I bracelet off his wheelchair e on 6/17/22, but staff were not	F 6	39		
	social services (Simplemented with adding R1 was well "he talks when he SS-A, the session see if R1 had a specific second	w on 6/28/22, at 5:16 p.m., S)-A, stated one to one's were R1 following the elopement, elcomed to come in and visit; wants to talk." According to as were proactivemore apt to becific needable to gauge his viors and moodintervene if				
	activities director sessions with R1 the activities depart	w on 6/28/22, at 5:20 p.m. (AD)-A stated one to one occurred with SS-A and staff in ortment. These sessions were by were informal and the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245290	B. WING			C 06/30/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1003 WEST MAPLE OLIVIA, MN 56277	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	participated in active department on a dadding R1 was out activities. During an interview at 6:20 p.m. in his was going to go he just left." R1 stated went two or three keeps before a man picket it was." R1 stated his collections [coin had a WanderGua off, adding he borret they put the pills or drawer. R1 opened and said, "It's gone know what day it we bracelet, adding artaken off by staff. During an interview DON stated when elopement on 6/18 (SS)-A instructed seps bracelet to R1, how started on 6/20/22, and VPCS-E to removing it, adding removed." On 6/23	defined. AD-A stated R1 vities offered by the activity aily basis, including weekends, of his room often attending v and observation on 6/28/22, room, R1 stated, "That day I me and I didn't tell anyone. I I it was 90 degrees and he only blocks, traveling on the street ed him up. "I have no idea who ne went home to get some of ns and marbles]. R1 stated he rd bracelet on his leg but cut it owed a scissor "from the cart n," then put the bracelet in a d a drawer underneath a closet e, I gave it to them." R1 did not ras when he cut off the nother one was put on, but later v on 6/29/22, at 9:54 a.m. the R1 returned after his /22, social services director staff to apply a WanderGuard vever, when the investigation they were instructed by RC-D move it as R1 didn't need it. The dragged her feet in g, "I didn't think it should be lagain instructed her to	F 6				
	remove it. The DO 6/24/22. The DON elopement risk, ad he gets upset, his	N stated it was left on until stated R1 was still at risk for ding, "He said he won't, but if M.O. (modus operandi) is to					

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			C 06/30/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1003 WEST MAPLE OLIVIA, MN 56277	² CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	5.475	
F 689	gave an examples under the bed bed day when he faked ER. "He gets mad During a telephone a.m. (FM)-H and (the incident and he hearing about the facility should, "ge R1's wheelchair." the facility that R1 person, and could FM-I stated the facility that R1 person, and could FM-I stated the facility policy that dated 6/20/22, creelopement, indicated the facility policy that R1 person, and could facility policy that R1 per	At had child-like behaviors, and of one day when he crawled ause he was mad and another da seizure and was sent to the and has no impulse control." The interview on 6/29/22, at 10:07 FM)-I stated they were aware of ad been concerned after elopement. FM-I stated the that WanderGuard back on FM-I stated they were told by was an adult and his own make decisions. In addition, cility told them they couldn't broke him to do things. FM-H know who picked up R1 and chance wanderGuard Policy ated in response to R1's ared all staff would be aware of a funsafe wandering and be to have a WanderGuard in the educated on the use of tursing staff will check residents and document it on the diministration record). The policy on want to do if the senot functioning properly. The interview on 6/29/22, at 3:07 for (MD)-G stated he R1 was ly intact, but lacked impulse and and holds a grudge and cand it was not safe for him to an his own without supervision	F 6	89			

245290 ENTER EMENT OF DEFICIENCIES	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD 1003 WEST MAPLE	•	C / 30/2022
EMENT OF DEFICIENCIES			•	
		OLIVIA, MN 56277		
JUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
e 11	F 68	39		
dding R1 was smart, but very ad if he didn't get his way ion seeking behavior. In., licensed practical nurse as a known elopement risk; i.e. "80% of the time, R1 is and 20% of the time he and can't think clearly; is like leaving last weekend." in., (TMA)-C stated R1 had ins, adding "we knew he is He liked to sit by the exit staff arrive to work. In., SS-A described R1's owever very impulsive when id not go his way, causing cisions.				
n SS-A on 6/28/22, at 5:16 ctions were taken after R1's acelet was immediately				
d a risk for elopement. The a WanderGuard was not in one opportunities with the staff and the SS in order ulsive behaviors by gauging				
	to R1's cognition and exit n., (TMA)-A stated R1 had dding R1 was smart, but very ad if he didn't get his way ion seeking behavior. n., licensed practical nurse as a known elopement risk; i.e. "80% of the time, R1 is and 20% of the time he and can't think clearly; is like leaving last weekend." m., (TMA)-C stated R1 had rs, adding "we knew he He liked to sit by the exit staff arrive to work. n., SS-A described R1's owever very impulsive when id not go his way, causing cisions. The eview and interviews with at 3:38 p.m. and on 6/29/22, in SS-A on 6/28/22, at 5:16 options were taken after R1's excelet was immediately in 6/18/22, and removed on the arrisk for elopement. The arrive to was not in the staff and the SS in order comportunities with the staff and the SS in order comportunities for him to an opportunities for him to an opportunities for him to	n., (TMA)-A stated R1 had dding R1 was smart, but very ad if he didn't get his way tion seeking behavior. n., licensed practical nurse as a known elopement risk; he. "80% of the time, R1 as and 20% of the time he and can't think clearly; s like leaving last weekend." m., (TMA)-C stated R1 had rs, adding "we knew he He liked to sit by the exit staff arrive to work. n., SS-A described R1's owever very impulsive when id not go his way, causing cisions. Teview and interviews with at 3:38 p.m. and on 6/29/22, and SS-A on 6/28/22, at 5:16 betions were taken after R1's accelet was immediately and 6/18/22, and removed on the day of the arrive was not in the staff and the SS in order culsive behaviors by gauging to opportunities for him to	n., (TMA)-A stated R1 had dding R1 was smart, but very ad if he didn't get his way ion seeking behavior. n., licensed practical nurse as a known elopement risk; ie. "80% of the time, R1 is and 20% of the time he land can't think clearly; is like leaving last weekend." im., (TMA)-C stated R1 had rs, adding "we knew he He liked to sit by the exit staff arrive to work. n., SS-A described R1's owever very impulsive when id not go his way, causing cisions. The eview and interviews with at 3:38 p.m. and on 6/29/22, in SS-A on 6/28/22, at 5:16 betions were taken after R1's accelet was immediately in 6/18/22, and removed on it was reassessed on id a risk for elopement. The a WanderGuard was not in one opportunities with the staff and the SS in order ulsive behaviors by gauging	n., (TMA)-A stated R1 had diding R1 was smart, but very did if he didn't get his way ion seeking behavior. n., licensed practical nurse as a known elopement risk; te. "80% of the time, R1 is and 20% of the time he and can't think clearly; s like leaving last weekend." mm., (TMA)-C stated R1 had rs, adding "we knew he He liked to sit by the exit staff arrive to work. n., SS-A described R1's owever very impulsive when id not go his way, causing cisions. Teview and interviews with at 3:38 p.m. and on 6/29/22, n SS-A on 6/28/22, at 5:16 stions were taken after R1's accelet was immediately in 6/18/22, and removed on d a risk for elopement. The a WanderGuard was not in one opportunities with the staff and the SS in order ulsive behaviors by gauging opportunities for him to

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245290	B. WING		06	C 5/ 30/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIE 1003 WEST MAPLE OLIVIA, MN 56277	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTIVE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	administrator state R1 eloped. The De elopement right av her team to complete State Agency, and to start the inv informed her team reach out to the co SS-A made the co elopement, "As a consultants arrived investigation. Whe VPCS-E directed to WanderGuard from administrator state RC-D and VPCS-I facility did not con addition, the consi- purposefully and ke therefore did not re Facility policy title 6/20/22, created in which indicated all residents at risk of aware of those wh place; staff would WanderGuard's; re wearing a Wander TAR; and what to properly. Facility policy title with revised date of facility would identified facility wo	w on 6/29/22, at 5:58 p.m., the ed she was out of town when ON made her aware of the way. The administrator directed ete a vulnerable adult report to to put a WanderGuard on R1, vestigation. Additionally, she is that if they needed help, to orporate nursing consultants. Insultants aware of the heads up." On 6/20/22, the dot to the facility to conduct the en asked why RC-D and the staff to remove the en R1 on 6/20/22, the ed it was her understanding at determined R1 leaving the stitute an elopement. In cultants determined R1 left the shear a WanderGuard. If WanderGuard Policy dated the response to R1's elopement, a staff would be aware of the staff to remove the the the the the way to the staff to remove the the	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245290	B. WING		06	C 06/30/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277	•	700,2022	
(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 CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	for residents. If idea or elopement, the include strategies the resident's safe characteristics or Ithat may indicate a the facility. This was verified to record review. The elopement risk, probracelet, added in implemented a powanderGuard bracelet, added in implemented a powanderGuard bracelet and documenting WanderGuard and re-education on elopement risk of care, and a complan of care was underGuard; states of care, and a complan of care was underGuard; states of care, and a complan of care was underGuard; states of care, and a complan of care was underGuard; states of care, and a complan of care was underGuard; states of care, and a complan of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard; states of care, and a complant of care was underGuard of care, and a complant of care was underGuard of care, and a complant of care was underGuard of care, and a complant of care was underGuard of care, and a complant of care was underGuard of care, and a complant of care was underGuard of care, and a complant of care was underGuard of ca	the least restrictive environment entified as a risk for wandering residents care plan would and interventions to maintain ty. The policy did not include behaviors to for staff to monitor a resident had intent to leave by observation, interview and a facility reassessed R1's ovided R1 with a WanderGuard terventions to R1's care plan, licy of verifying placement of celets on residents twice a day it, implemented audits of or all eight residents who have a diprovided all staff with		39			

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		06	C 06/30/2022	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1003 WEST MAPLE OLIVIA, MN 56277	-	/OU/LULL	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 689	severity level of level severity level, which	el, D, isolated scope and n indicated no actual harm with han minimal harm that is not	F 6	89			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00939		B. WING		C 06/30/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OLIVIA F	RESTORATIVE CARE	CENTER 1003 WES OLIVIA, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficion herein are not corrected shall with a schedule of fithe Minnesota Departments of the Minnesota Departments of the number and MN Rule When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
/linnesota D	conducted at your faminnesota Department facility was found National State Licensure. Plan of correction your family state of correction your family state.	S: /22, a complaint survey was acility by surveyors from the ent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders when they will be completed.				
	•	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(2	X6) DATE

Electronically Signed

07/22/22

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277 [K4] ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY/ING INFORMATION) The following complaint was found to be SUBSTANTIATED: H52902857C (MN84435) with a licensing order issued at 4658 0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statules/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio n/infobulletins/fbl.141hml The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER OLIVIA, MN 56277 (X4) ID PREFEIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) The following complaint was found to be SUBSTANTIATED: H52902657C (MN84435) with a licensing order issued at 4658.0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio n/infobulletins/bit 4_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction			A. BOILDING.		C	
CALIVIA RESTORATIVE CARE CENTER 1003 WEST MAPLE OLIVIA, MN 56277 CLIVIA, MN 56277		00939	B. WING		06/3	, 0/2022
CALIVIA, MIN 56277 CALIVIA, ID CARD EPROVIDER'S PLAN OF CORRECTION CASH	NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OLIVIA, MM 56277 OLIVIA, MM 56277 OLIVIA, MM 56277 CALIDA, MM 56277 CALIDA, MM 56277 CALIDA, MM 56277 CALIDA, MM 56277 PROVIDER'S PLAN OF CORRECTION BOOK SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FROM LSC IDENTIFYING INFORMATION) The following complaint was found to be SUBSTANTIATED: H52902657C (MM84435) with a licensing order issued at 4658.0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag number have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/ninfobulletins/bid-1_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	OLIVIA RESTORATIVE CARE (CENTER 1003 WES	T MAPLE			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52902657C (MN84435) with a licensing order issued at 4658.0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio n/infobulletins/fb14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	OLIVIA ILLO I OTILATIVE GATIL	OLIVIA, M	N 56277			
The following complaint was found to be SUBSTANTIATED: H52902657C (MN84435) with a licensing order issued at 4658.0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
SUBSTANTIATED: H52902657C (MN84435) with a licensing order issued at 4658.0520 subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000 Continued From page	ge 1	2 000			
is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	SUBSTANTIATED: a licensing order iss Minnesota Departm the State Licensing Federal software. To assigned to Minneson Nursing Homes. The appears in the far-lettag." The state state listed in the "Summa column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Marine Period for Cornyou have agreed to receipt of State licenthe Minnesota Department of Heal you electronically. A significant of the Minnesota Department of Heal you electronically. A significant is necessary for State enter the word "Collavailable for text. You electronic State licenthe Minnesota Department of the	ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" is the "To Comply" portion of a This column also includes are in violation of the state tement, "This Rule is not met allowing the surveyor's findings whethod of Correction and arection. Participate in the electronic insure orders consistent with a state. The state licensing and on the attached Minnesota in the orders being submitted to although no plan of correction at Statutes/Rules, please in the orders will be electronically submitting to a the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	COMPLETED		
		00939	B. WING		C 06/30/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OLIVIA R	ESTORATIVE CARE	CENTER	ST MAPLE IN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE	2 000			
2 830	Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as pwritten order from the comprehensive plan of care from the comprehensive plan of care as design the care as design the care as design the care as design to care as design the care as design to care as design the care as design to care as desi	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and and home resident must be out possible unless there is a he attending physician that the in in bed or the resident				7/22/22
	Based on interview, review, the facility fasupervision despite risk, for 1 of 1 residence self-propelling in a verturning to his home air temperature at 9 stranger subsequer away from the facility home in the community immediate jeopardy was returned to the	ent is not met as evidenced, observation, and document ailed to provide adequate being a known elopement ents (R1) who left the facility, wheelchair with the intent of ne, over a mile away, with an 00 degrees Fahrenheit (F). Antly picked up R1 a few blocks ty and brought him to R1's unity. This resulted in an (IJ) for R1 when, after he facility on 6/18/22, the facility ventions that would prevent		On 6/29/22 a WanderGuard was reback on R1. R1's care plan was choreflect the use of the WanderGuard and an elopement risk assessment completed. Staff were educated or updated care plan. R1 will continue have 1 to 1 meetings with activities social services, and will be offered or individual outings twice weekly. To prevent further incidents to all of potential residents, all WanderGuard be checked by the nurse on each services.	nanged lard, it was n R1's e to s and group other ards will	

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION :	COMPLETED		
		00939	B. WING		C 06/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OLIVIA F	RESTORATIVE CARE	CENTER 1003 WES	ST MAPLE IN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL (EACH CORRECTIVE ACTION SHOUL)	D BE	(X5) COMPLETE DATE
2 830	The IJ began on 6/1 to place intervention again and was iden administrator and donotified of the IJ on was removed on 6/3 facility implemented further elopements, at the lower scope a isolated scope, and no actual harm with minimal harm that is Findings include: R1's facesheet printing diagnoses of adjust disturbance of emodisease, high blood	ng R1 at risk for serious harm, e should elope again. 18/22, when the facility failed his to prevent R1 from eloping tified on 6/29/22. The lirector of nursing (DON), were 6/29/22, at 4:28 p.m. The IJ 30/22, at 1:53 p.m. when the dinterventions to prevent, but noncompliance remained and severity level 2, D, I severity level, which indicated a potential for more than is not immediate jeopardy. Ited on 6/28/22, included a timent disorder with mixed tions and conduct, heart pressure, heart failure (when timp as well as it should), and		residents with an elopement risk hareflected in their care plan. All WanderGuards are checked on earn all staff were re-educated on the elopement policy and the use of WanderGuards. A root cause analysis was completed to be a failure in follow manufacture instructions to have the WanderGuard checked daily. The checks of the WanderGuard's manufactured instructions were implemented, with the charge nurse checking them once on each shift. WanderGuard check was added to TAR to be signed off by the nurse. Staff were reeducated on our elope policy and R1's care plan. The DON or designee will complete on the WanderGuards were completed days and wanderGuards wanderGuards wanderGuards were completed days and wanderGuards wanderGuards wanderGuards w	ted for se was ing the daily se Eurther, ement	
	4/15/22, indicated F clear speech, was understand. R1 was on the unit in his whom supervision off the conce or twice during In addition, the MDS wander/elopement R1's plan of care pridentify elopement R1's Elopement	num Data Set (MDS) dated R1 was cognitively intact, had understood and could independent in moving about neelchair but required unit. Walking occurred only g the MDS assessment period. S indicated a alarm was not used. Tinted on 6/28/22, did not as a focus area of concern. Sk Evaluation, dated 4/15/22, score of seven indicating he		weeks then randomly and will remain the TAR for the nurse to check each Results of the audits will be brough QAPI for discussion and review.	ch shift.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	00939	B. WING		C 06/30/2022		
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE	1003 WES	DRESS, CITY, ST ST MAPLE IN 56277	TATE, ZIP CODE	-		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
upon the following 1. Ability to self-pro 2. Habit/history of vithe building 3. Exhibited agitate 4. Asked to go hom 5. Had a psychiatric 6. Family had voice a tendency to wand 7. Taking medication An intervention che evaluation form incaccording to the diran interview on 6/2 WanderGuard brack residents, who when the door automatical resident from leaving the elopement risk wanderGuard was Discrepancies were documentation on thave a WanderGuard was Discrepancies were documentation indicated mention a Wander Guard MDS indicated here a Evaluation indicated mention a Wander Guard go on pass a with responsible a part of the facility of the facility out on pass and visits was concerned about ability to make information of the facility to make information of the facility to make information and the facility to make information of the facility to make information and the facility to make infor	ement. The score was based seven parameters: pel wheelchair vandering or attempts to leave d behavior ne c diagnosis ed concerns that R1 may have der or elope on which may cause confusion ecked off on the elopement risk luded, "exit alarm" which, rector of nursing (DON) during 9/22, at 9:15 a.m., meant a selet (a device worn by en in the vicinity of an exit door, ally locks preventing the ng unattended). According to evaluation form, a in use at that time, 4/15/22. The noted in the facility whether R1 had or did not ard in place on 4/15/22. The did not. Elopement Risk d he did. The care plan did not					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED			
		00939		B. WING			C 06/30/2022	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
OLIVIA F	RESTORATIVE CARE	CENTER	1003 WES OLIVIA, M					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOUTH)	ULD BE	(X5) COMPLETE DATE	
2 830	Continued From page 5		2 830					
	as well. R1 had significant behaviors in the past including suicidal gesturing. The physician noted he would seek psychiatric input into his mental status. A psychiatry note dated 4/28/22, indicated R1 was impulsive and his lack of insight extended to his desire to go home. A psychiatry note dated 5/31/22, indicated R1 lacked safety awareness, had short term memory impairment and impairment in concentration.							
	A progress note dated 6/17/22, indicated R1 was seen by a physician on routine rounds and R1 was upset and venting to the physician about wanting to go home and wanting all of his collections (coins and marbles) brought to the facility. The physician was informed that R1 never really slept and spent all day and night in his wheelchair with an occasional half hour in his recliner. The physician ordered Ativan (medication to relieve anxiety) to be administered one half hour before bedtime.							
	indicated the facility member (FM)-C whome in the community wheelchair. The DC advised to call law ereturn him to the facility	ted 6/18/22, at 6:33 per received a call from no stated R1 arrived to unity at 4:15 p.m. in his enforcement to pick unity. R1 returned at 4 and no injuries were a	family o his is taff were p R1 and l:50 p.m.					
	p.m. by the DON rethe charge nurse reR1 had left the build gone home. Per the propelled his wheel	completed on 6/18/22, at 4 aceived a call from R1 ding in his wheelchair wife's explanation, he chair part way and was lick up [truck] and take	:15 PM, 's wife. and e as picked					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED	
00939		B. WING			C 06/30/2022	
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, S	STATE, ZIP CODE		
OLIVIA F	RESTORATIVE CARE	CENTER	WEST MAPLE IA, MN 56277			
(X4) ID PREFIX TAG	VEACUL DEFICIENCY (AUTOF DE DDECEDED DY VEUL		ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	to go home.' 'I didn'd DON was called whimmediately call 01 to the home address R1 back to the nurse and oriented. The inwere no predisposit active exit seeker. If wanted a young girl told she could not. I home" to get his may witnesses were fou DON, administrator physician were notification on duty when R1 el 3:00 p.m. on 6/18/2 because he wanted him a bath and that According to TMA-FM-C called the fact p.m. to report R1 which stated they were not building, adding the between his room at telling anyone. TMA-FM-C called the fact p.m. to report R1 which stated they were not building, adding the between his room at telling anyone. TMA-FM-C called the fact p.m. to self-propel out for a bit. TMA-B stated they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone. TMA-FM-C called they were not building, adding the between his room at telling anyone.	ne. R1 informed staff, 'I wan't do anything wrong.' The no advised charge nurse to 1 [911] and ask for police to shere in community and being home. No injuries. Alerncident report indicated the ng situational factors, includent was upset because he I to give him a shower and He also "just wanted to go arbles and coin collections. Ind. Following the incident, or, social services and R1's fied." Ton 6/28/22, at 2:11 p.m. aide (TMA)-B stated at about 22, R1 had been upset a certain employee to give the employee could not. B, the next thing she knew, cility at approximately 4:15 as at her house. TMA-B of aware R1 had left the later R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of and the nurses station without R1 had gone out an exit of anything R1 had gone out an exit of anything R1 had gone out anything	door out an or it do 14 A up.			

Minnesota Department of Health

AND PLAN OF CORRECTION DENTIFICATION NUMBER:		` ′	CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED	
		B. WING		C 06/30/2022		
	PROVIDER OR SUPPLIER	CENTER 1003 WE	DDRESS, CITY, STEET MAPLE MN 56277	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	had been sitting on needed help; R1 as house. FM-C stated hot that day, "I think wheelchair, self-producted that day, "I think wheelchair, self-producted that the far R1 got before the "we live clear across she told the man R he exited real quick here and was lookind doesn't understand valuable to the nurshe wanted when he look at his marble of thought the time wanot sure. FM-C states since 2/3/22, and he before. When asked on is body or wheel put one on and he commething bad enought one on and he commething bad enought. She was at the 6/17/22, for beer are he cut off his Wandstated she didn't kn R1 fibs a lot, so she According to websit temperature in the 6/18/22, was 93 decording an interview DON stated on 6/18 charge nurse called the facility to inform The DON advised senforcement pick he facility. The DON the	w this man who told her R1 the road so he asked R1 if he sked him to take him to his d R1 was exhausted and it was k he pushed himself in the opelling, that wears him out. at day." FM-C didn't know how he man picked him up, adding, s down." FM-C stated when 1 wasn't supposed to be here, he FM-C stated, R1, "Flew in hig for something. Money. He it's not safe to take everything high home, that's mainly what he came home, he wanted to collection." FM-C stated she has about 6:00 p.m., but was hed R1 had lived at the facility had not tried to go home d if R1 had an alarm bracelet he chair, FM-C stated no, "they but it off," adding, if R1 wants he facility the evening of he don't report this to the staff. He www.accuweather.com, the community on the afternoon o				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
7 12 . 27 1			A. BUILDING:				
	00939		B. WING			3 0/2022	
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
OLIVIA RESTORATIVE CARE	CENTER	1003 WES	ST MAPLE IN 56277				
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to talk to staff. Fifte initiated. The DON on Monday 6/20/25 (RC)-D and vice p (VPCS)-E arrived included a care co other family membranily stated they to happen sooner threaten it all the tinot unhappy at the home and get his expected and the side elopement. The Downson of WanderGuard braunbeknownst to the time, the facility waverification of WanderGuard brashed if the facility was cognition), so a WanderGuard this mental status) was cognition), so a WanderGuard brashed in the Downson of WanderG	een minute check stated the invest 2, when a regional esident of clinical to the facility. The ofference with R1 ers. According to were expecting it because R1 called the me. The DON stated R1 had considered and a resider de door on the data conducting der Guard bracele fore it went under the considered in the co	igation started al consultant al services investigation, FM-C, and the DON, the [elopement] of them and ated R1 was ranted to go collections. At who R1 by of he did a 8/22, when the off. At that daily ets on etected. When reapplying the elopement risk for ere told by ment was rview for tact and the off their oncluded the nt' because the was going.					
conversation and sinvestigation that a necessary becaus purposefully and k for those reasons elopement.	WanderGuard we R1 left the faciline were ween ween ween ween we want to be well and the ween well and the	vas not ty as going, and					

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE		
		1003 WE	ST MAPLE			
OLIVIA F	RESTORATIVE CARE	CENTER OLIVIA, I	MN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 9		2 830			
	placed a phone call "We're not calling it he was doing. He p for him to leave the own person and his a WanderGuard wa adding, "He's a guy He collects stuff and it." VPCS-E stated the WanderGuard k would not be effecti implemented one to was more proactive his own person." VE R1's behaviors, he why we added imple The facility did not re	terview, at 4:00 p.m., the DON I to VPCS-E who stated, an elopement. He knew what blanned to leave. It was safe facility unsupervised - he's his BIMS is 14." VPCS-E stated as not appropriate for R1, I would let sign out and go. I would let sign out and go. I wanted to go home and see R1 had the capability to cut bracelet off and therefore it live. VPCS-E stated the facility one activities with R1 which is and they educated R1; "He's PCS-E stated they "Reviewed the rolls away, gets mad, that's culsiveness to his care plan." require residents to sign out to enjoy the weather.				
	DON stated Wands at the facility in Apri secure unit. R1 had placed on his whee elopement risk eval DON, the placement of Wand after the elopement of Wand after the elopement the WanderGuard be around suppertime aware of this. During an interview social services (SS)	on 6/28/22, at 5:06 p.m., the erGuard's were implemented if 2022 when they closed their a WanderGuard bracelet elchair just prior to a 4/15/22, luation, but according to the at date was not documented. Ithe facility was not verifying derGuard's on residents until tincident on 6/18/22. R1 cut bracelet off his wheelchair on 6/17/22, but staff were not on 6/28/22, at 5:16 p.m.,)-A, stated one to one's were				
	implemented with Fadding R1 was weld	R1 following the elopement, comed to come in and visit; vants to talk." According to				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00939	B. WING			C 30/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
OLIVIA F	RESTORATIVE CARE	CENTER	EST MAPLE MN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	see if R1 had a specompulsive behavior needed. During an interview activities director (A sessions with R1 or the activities depart not scheduled, they frequency was not or participated in activities department on a data adding R1 was out activities.	were proactivemore apt to cific needable to gauge his ors and moodintervene if on 6/28/22, at 5:20 p.m. AD)-A stated one to one ccurred with SS-A and staff in ment. These sessions were were informal and the defined. AD-A stated R1 ities offered by the activity illy basis, including weekends of his room often attending				
	at 6:20 p.m. in his ray was going to go hor just left." R1 stated went two or three by before a man picke it was." R1 stated his collections [coin had a WanderGuar off, adding he borrow they put the pills on drawer. R1 opened and said, "It's gone know what day it was bracelet, adding an taken off by staff. During an interview DON stated when Felopement on 6/18/(SS)-A instructed started on 6/20/22,	and observation on 6/28/22, oom, R1 stated, "That day I me and I didn't tell anyone. I it was 90 degrees and he only locks, traveling on the street d him up. "I have no idea who e went home to get some of s and marbles]. R1 stated he d bracelet on his leg but cut it wed a scissor "from the cart," then put the bracelet in a a drawer underneath a close a drawer underneath a close of I gave it to them." R1 did not as when he cut off the other one was put on, but late on 6/29/22, at 9:54 a.m. the R1 returned after his 22, social services director aff to apply a WanderGuard ever, when the investigation they were instructed by RC-Dave it as R1 didn't need it.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
OLIVIA F	RESTORATIVE CARE	CENTER	ST MAPLE MN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	removing it, adding removed." On 6/23/was still on R1 and remove it. The DON 6/24/22. The DON selopement risk, adding the gets upset, his Neave. This was his The DON stated R1 gave an examples of under the bed becard day when he faked ER. "He gets mad a During a telephone a.m. (FM)-H and (Fithe incident and had hearing about the efacility should, "get R1's wheelchair." Fithe facility that R1 with person, and could refine facility that R1 with person R1 and for stated they did not light dated 6/20/22, created by and the growided guidance of those who place; staff would be wander Guard's; not wearing a Wander Guard's wearing a Wander Guard's	e dragged her feet in , "I didn't think it should be 22, RC-D saw the bracelet again instructed her to I stated it was left on until stated R1 was still at risk for ling, "He said he won't, but if II.O. (modus operandi) is to first time; but it's a possibility. I had child-like behaviors, and of one day when he crawled use he was mad and another a seizure and was sent to the and has no impulse control." interview on 6/29/22, at 10:07 M)-I stated they were aware of been concerned after lopement. FM-I stated the that WanderGuard back on M-I stated they were told by was an adult and his own make decisions. In addition, lity told them they couldn't ree him to do things. FM-H know who picked up R1 and shome. Iled WanderGuard Policy ted in response to R1's ad all staff would be aware of unsafe wandering and be a have a WanderGuard in e educated on the use of ursing staff will check residents and and document it on the ministration record). The policy	of S			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
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p.m., medical doctor probably cognitively control; "He gets macts out." MD-G acawareness and state leave the facility on as he did on 6/18/2 Interviews pertaining seeking behaviors:6/28/22, at 3:30 p not eloped before, simpulsive. R1 got mit's almost like atte6/28/22, at 3:36 p (LPN)-A stated R1 he wanted to go homakes good decisied did not. He gets mamakes poor decision6/29/22, at 11:58 exit seeking behavious wanted to go home doors and watch the6/29/22, at 3:20 p cognition as intact, frustrated or things him to make poor of the DON on 6/28/22 at 9:54 a.m., and we p.m., the following a elopement:A WanderGuard by placed on his chair 6/24/22R1's elopement ri	interview on 6/29/22, at 3:07 or (MD)-G stated he R1 was a intact, but lacked impulse ad and holds a grudge and knowledged R1 lacked safety ted it was not safe for him to his own without supervision 2. g to R1's cognition and exit a.m., (TMA)-A stated R1 had adding R1 was smart, but very had if he didn't get his way antion seeking behavior. a.m., licensed practical nurse was a known elopement risk; me. "80% of the time, R1 ons and 20% of the time he ad and can't think clearly; ons like leaving last weekend." a.m., (TMA)-C stated R1 had ors, adding "we knew he" He liked to sit by the exit e staff arrive to work. a.m., SS-A described R1's however very impulsive when did not go his way, causing					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	00939	B. WING		06/30	0/2022
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENT	1003 WES	T MAPLE	STATE, ZIP CODE		
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2 830 Continued From page 13	3	2 830			
evaluation indicated a WuseProvided R1 one to on activities department stated decrease R1's compulsion R1's mood and allow opexpress concerns. The fidefined.	e opportunities with the aff and the SS in order ve behaviors by gauging portunities for him to				
administrator stated she R1 eloped. The DON may elopement right away. Ther team to complete a state of the State Agency, to put and to start the investigation of the corporal SS-A made the consultate elopement, "As a heads consultants arrived to the investigation. When ask VPCS-E directed the state of t	ade her aware of the he administrator directed vulnerable adult report to a WanderGuard on R1, ation. Additionally, she of they needed help, to the nursing consultants. Into aware of the up." On 6/20/22, the efacility to conduct the ed why RC-D and aff to remove the on 6/20/22, the as her understanding the an elopement. In the determined R1 leaving the an elopement. In the determined R1 left where he was going, and a WanderGuard. In derGuard Policy dated onse to R1's elopement, would be aware of fe wandering and be ea WanderGuard in ucated on the use of graff will check residents of and document it on the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00939	B. WING			C 30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
TO THE OT	THO VIDENT ON CONTINUENT		ST MAPLE	717 (1 L, 2 ll 00 D L		
OLIVIA F	RESTORATIVE CARE	CENTER	MN 56277			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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2 830	Continued From pa	ge 14	2 830			
	properly.					
	with revised date of facility would identifunsafe wandering a while maintaining the for residents. If identifor elopement, the reinclude strategies a the resident's safety characteristics or be	Wandering and Elopement, March 2019, indicated the y residents who are at risk of and strive to prevent harm he least restrictive environmentified as a risk for wandering esidents care plan would and interventions to maintain y. The policy did not include ehaviors to for staff to monitor resident had intent to leave				
	record review. The elopement risk, problem bracelet, added interimplemented a policy wanderGuard bracelet and documenting it. WanderGuard's for	robservation, interview and facility reassessed R1's vided R1 with a WanderGuard reventions to R1's care plan, by of verifying placement of elets on residents twice a day, implemented audits of all eight residents who have a provided all staff with pement.				
	was removed on 6/2 WanderGuard brack plan of care was up WanderGuard; staff of care, and a comp R1's elopement risk to reduce the risk of one opportunities w services to identify a behavior to elope; g would be offered to also conducted aud	pardy that began on 6/18/22, 29/22, when R1 had a elet placed on his ankle; his plated to reflect the use of the were educated on R1's plan prehensive reassessment of a was completed. Interventions of elopement included: one to with activities staff and social and decreased impulsive group and individual outings R1's twice weekly. The facility lits on residents with a sily for two weeks and	S			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED		
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2 830	Continued From particular verification would or charge nurse to che not yet educated or and the elopement Noncompliance renseverity level of lever severity level of lever severity level, which potential for more the immediate jeopardy. SUGGESTED MET The director of nurser review/revise policies appropriate supervirespond to exit-see designee could also comprehensive assement with the potential to designee could results of assessment for exit-seeking behavior of a seeking behavio	ccur on the TAR eck each shift. All the use of Wand policy were eductatined at the low el, D, isolated so indicated no act an minimal harm. HOD OF CORRISING (DON) or design to prevent eking behavior. The and ensure appleants for those identicate all staff or anges to care played anyons and elope ould develop a syntoring consistent or those identicates and proceed aviors and elope ould develop a syntoring consistent or those identicates and proceed aviors and elope ould develop a syntoring consistent or staff perform a ressment or root of the ensure intervent of the evaluated and re-evaluated a	I nursing staff derGuard's ated. er scope and tual harm with that is not entered to lopement or ne DON or or policies and, and the entified at risk ement. The extern for the dures and sand/identify designee cause entions are as often as a surable the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are as often as a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility's provement or ne designee cause entions are a surable of the facility of the facility or ne designee cause entions are a surable of the facility of the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/01	J/LULL
OLIVIA R	ESTORATIVE CARE	CENTER	ST MAPLE IN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE