



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2026

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

RE: CCN:245290
Cycle Start Date: July 22, 2026

Dear Administrator:

On July 22, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 22, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 22, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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



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OLIVIA RESTORATIVE CARE CENTER

1003 WEST MAPLE AVENUE

OLIVIA, MN 56277

Re: State Nursing Home Licensing Orders

Event ID: 285BFC-H1

Dear Administrator:

The above facility survey was completed on July 22, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 only a suggestion 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 "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:

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/17/26 and 7/21/26 through 7/22/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52903374C (3096608) and H52903375C (3096578, 3123047, 3122696) with a citation at F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/11/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			F0755	Immediate action(s) taken for the resident(s) found to have been affected include: Review of all resident's medications in the building. If medications were not in the building, pharmacy and MD/NP were notified. R2 (PM) was affected. Pain was assessed. Pharmacy was contacted on 7-21-26. NP was contacted for script on 7-21-26. Medication was received on 7-21-26. R3 (RO) was affected. Pain was assessed. Pharmacy delivered medications on 7-21-26. Identification of other residents having the potential to be affected was accomplished by:		08/21/2026

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

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

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F0755 SS = D	Continued from page 1 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications used to manage pain were provided timely after being ordered, despite a supply of the medication being available in the onsite emergency kit (E-Kit), for 2 of 3 residents (R2, R3) reviewed. Findings include: R2: R2's provider orders dated 7/15/26 instructed pregabalin (a medication for nerve pain) 20 milligrams (mg) per milliliter (mL) oral solution give 3.75 mL via G-tube (a flexible medical device placed through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medications) in the evening (5:00 p.m.) and 6.25 mL at bedtime (8 p.m.) for polyneuropathy. R2's Brief Interview for Mental Status (BIMS) dated 7/20/26 indicated intact cognition. R2's diagnoses list dated 7/21/26 included hypertension, anxiety, injury of the esophagus, polyneuropathy (numbness and tingling usually in the feet and hands) and pain. R2's medication administration record (MAR) for			F0755	Continued from page 1 The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: TMA's and Nurses received education on "Medications not on Hand" and procedure. Education to be completed by 8-21-26 by all TMA's and Nurses otherwise TMA's and Nurses will have to complete before the beginning of their next scheduled shifts. Education Material lists steps to follow if medications are not in the facility or on hand including accessing on-site e-kit and documentation in progress notes of communication to fix not having the medication in the building. All Residents to be reviewed for medications in the building Monday through Friday. How the corrective action(s) will be monitored to ensure the practice will not recur: The (DON/Administrator/Dietary Manager/Social Services Directors, etc.) will complete daily audits of medications not in the building x 2 weeks; then weekly x4 weeks; then monthly x3 months; and then prn. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. =		08/21/2026

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F0755 SS = D	Continued from page 2 July 2026 identified R2 did not receive 9 doses of the ordered pregabalin from 7/15/26 through 7/20/26 as indicated by a blank box (lack of administration information) or a "9" which instructs "see progress note." R2's nursing note dated 7/17/26 indicated R2 was sent to the hospital at 1:00 p.m. for a scheduled procedure and a nursing note on 7/18/26, identified she returned between 5:00 p.m. and 8:30 p.m. R2's nursing note dated 7/19/26 at 12:30 a.m., indicated pregabalin was "not available". R2's nursing note dated 7/19/26 at 5:14 p.m., indicated pregabalin "will administer as soon as pharmacy delivers". R2's nursing note dated 7/19/26 at 8:21 p.m., indicated pregabalin was "not available". R2's nursing note dated 7/20/26 at 8:29 p.m., indicated pregabalin was "not available". R2's nursing notes, from 7/19/26 through 7/20/26, lacked evidence staff contacted the pharmacy, the provider, or utilized available pregabalin from the E-Kit in relation to this medication not being available. A pharmacy email, sent to the facility on 7/22/26 at 3:52 p.m., indicated the following was identified from the pharmacy call logs: •A "Script" was received on 7/21/26 at 9:14 a.m. •A "Call" was received on 7/21/26 at 6:38 p.m.: "checking on status - facility staff informed pregabalin would be on 1st delivery." •"Medication delivered 7/21 at 10:10pm". During an interview on 7/21/2026 at 11:16 p.m., R2 stated she took pregabalin for neuropathy in her feet, but it had not been working as well lately. In the past she did not have pain or tingling in her feet but now she does. R2 was currently utilizing an opioid pain medication that relieves the pain but not			F0755			08/21/2026

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F0755 SS = D	Continued from page 3 the tingling. R3: R3's provider order dated 7/14/26 instructed pregabalin give 150 mg by mouth three times a day for pain. R3's BIMS dated 7/16/26 indicated moderately impaired cognition. R3's diagnoses list dated 7/21/26 included encephalopathy, aspiration pneumonia, acute respiratory failure and hypertension. R3's MAR for July 2026 identified R3 did not receive 21 doses of pregabalin from 7/14/26 through 7/21/26 as indicated by a documented "9." R3's nursing notes dated 7/14/26 through 7/21/26 identified the pregabalin tablets were "not available", "medication not delivered by pharmacy, will f/u", "medication not on hand", "waiting on pharmacy new resident", "waiting on order", "med not available. Nurse notified", and "medication not here charge nurse called pharmacy and it will be delivered tonight". A pharmacy email, sent to the facility on 7/22/26 at 3:52 p.m., indicated the following calls from the facility were found on the pharmacy call logs: •Call received 7/15/26 at 12:51 a.m.: the tech informed facility staff that they did not receive scripts with admission. •Script received 7/18/26 at 10:20 a.m.: patient name and date of birth (DOB) on the script did not match what was on file wih the pharmacy. •Call received 7/20/26 at 7:57 p.m.: the tech informed facility staff that they still had not received a script for pregabalin. "I believe this is because of the mismatched name spelling and DOB." •Call received 7/21/26 at 4:52 p.m.: checking on status - facility staff informed pregabalin would be on 1st delivery.			F0755			08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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F0755 SS = D	Continued from page 4 •Call received 7/21/26 at 7:16 p.m.: E-Kit code requested for Lyrica (pregabalin). •On 7/21/26, at 10:10 p.m., the medication was delivered During an interview on 7/21/2026 at 1:31 p.m., R3 stated he had neuropathy that made his feet very tingly. Usually, the pregabalin took the tingling away, but right now the tingling has been bad. R3 thought he was taking pregabalin but could not remember if he took it that morning. During an interview on 7/21/2026 at 1:39 p.m., trained medication assistant (TMA)-A stated that if a medication was not in the medication cart, he would look for it in the medication room. If the medication was not in the medication room, he would notify the nurse and document that the medication was unavailable and that the nurse had been notified. During an interview on 7/21/2026 at 3:53 p.m. TMA-B stated if a medication was not in the medication cart, she would look for it in the medication room. If the medication was not in the medication room, she would notify the nurse and document that the medication was unavailable. During an interview on 7/21/2026 at 2:20 p.m., licensed practical nurse (LPN)-A stated a nurse needed to reorder any controlled medications. The TMA would notify the nurse when the medication was getting low. The nurse would contact the pharmacy to see if any refills remained. If the medication required a new order, the nurse would contact the provider for an order. If there was an active order, the nurse could obtain a code for the E-Kit from the pharmacy so the medication could be administered at the correct time. LPN-A did not recall if she was notified about R2 or R3's pregabalin. During an interview on 7/21/2026 at 2:39 p.m., the pharmacist (Pharm-D) stated when the pharmacy needs a prescription for a medication, they will put the information into the electronic record and pharmacy dashboard. The order will be flagged as needing a prescription. Pharm-D stated the pharmacy did not receive a prescription for R2's pregabalin until 7/21/26. Pharm-D confirmed there was no communication from the facility regarding			F0755			08/21/2026

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F0755 SS = D	Continued from page 5 R2's pregabalin. Pharm-D stated they received a prescription for R3's pregabalin on 7/18/26 but R3's date of birth was incorrect. Pharm-D stated there were notifications to the facility about contacting the provider to correct the date of birth, but the pharmacy did not receive the corrected prescription until 7/21/26. Pharm-D confirmed the facility had pregabalin in the e-kit, but the facility had not contacted pharmacy for the code required to access the E-Kit. During an interview on 7/21/2026 at 4:09 p.m., the director of nursing (DON) stated a TMA would alert the nurse if a medication was unavailable. The nurse would contact the pharmacy to see why the medication had not been sent. The nurse should request a code for the E-Kit if the resident had a current prescription or should contact the provider for a new prescription. The nurse should document calling the pharmacy and any provided information as well as if the provider was notified about needing a prescription and/or the resident not receiving ordered medication. The nurse manager and DON had access to the pharmacy dashboard where communication was placed from pharmacy about medication that had been reordered, medications that were ordered too early, medications that were being sent in the next delivery, medications that needed new prescriptions and other information about medication. DON stated she had just found out R2 and R3 had not been receiving their ordered pregabalin and confirmed there were no notes written by a nurse about contacting the pharmacy or provider. DON stated all residents should receive their ordered medications so they can be stable and free of pain. A call was placed to nurse practitioner on 7/21/2026 at 3:27 p.m. with no return phone call. The Medication administration policy dated 6/12/24 instructed medications to be administered as ordered by the physician.			F0755			08/21/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/17/26 and 7/21/26 through 7/22/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52903374C (3096608) and H52903375C (3096578,		20000			08/11/2026	

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE , OLIVIA, Minnesota, 56277			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20000	Continued from page 1 3123047, 3122696) with a licensing order issued at 1550. 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/regulation/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 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 state form. 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.			20000			08/11/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by:			21550	Immediate action(s) taken for the resident(s) found to have been affected include: Review of all resident's medications in the building. If medications were not in the building, pharmacy and MD/NP were notified. R2 (PM) was affected. Pain was assessed. Pharmacy		08/21/2026

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21550	Continued from page 2 Based on interview and document review, the facility failed to ensure medications used to manage pain were provided timely after being ordered, despite a supply of the medication being available in the onsite emergency kit (E-Kit), for 2 of 3 residents (R2, R3) reviewed. Findings include: R2: R2's provider orders dated 7/15/26 instructed pregabalin (a medication for nerve pain) 20 milligrams (mg) per milliliter (mL) oral solution give 3.75 mL via G-tube (a flexible medical device placed through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medications) in the evening (5:00 p.m.) and 6.25 mL at bedtime (8 p.m.) for polyneuropathy. R2's Brief Interview for Mental Status (BIMS) dated 7/20/26 indicated intact cognition. R2's diagnoses list dated 7/21/26 included hypertension, anxiety, injury of the esophagus, polyneuropathy (numbness and tingling usually in the feet and hands) and pain. R2's medication administration record (MAR) for July 2026 identified R2 did not receive 9 doses of the ordered pregabalin from 7/15/26 through 7/20/26 as indicated by a blank box (lack of administration information) or a "9" which instructs "see progress note." R2's nursing note dated 7/17/26 indicated R2 was sent to the hospital at 1:00 p.m. for a scheduled procedure and a nursing note on 7/18/26, identified she returned between 5:00 p.m. and 8:30 p.m. R2's nursing note dated 7/19/26 at 12:30 a.m., indicated pregabalin was "not available". R2's nursing note dated 7/19/26 at 5:14 p.m., indicated pregabalin "will administer as soon as pharmacy delivers".			21550	Continued from page 2 was contacted on 7-21-26. NP was contacted for script on 7-21-26. Medication was received on 7-21-26. R3 (RO) was affected. Pain was assessed. Pharmacy delivered medications on 7-21-26. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: TMA's and Nurses received education on "Medications not on Hand" and procedure. Education to be completed by 8-21-26 by all TMA's and Nurses otherwise TMA's and Nurses will have to complete before the beginning of their next scheduled shifts. Education Material lists steps to follow if medications are not in the facility or on hand including accessing on-site e-kit and documentation in progress notes of communication to fix not having the medication in the building. All Residents to be reviewed for medications in the building Monday through Friday. How the corrective action(s) will be monitored to ensure the practice will not recur: The (DON/Administrator/Dietary Manager/Social Services Directors, etc.) will complete daily audits of medications not in the building x 2 weeks; then weekly x4 weeks; then monthly x3 months; and then prn. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		08/21/2026

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21550	Continued from page 3 R2's nursing note dated 7/19/26 at 8:21 p.m., indicated pregabalin was "not available". R2's nursing note dated 7/20/26 at 8:29 p.m., indicated pregabalin was "not available". R2's nursing notes, from 7/19/26 through 7/20/26, lacked evidence staff contacted the pharmacy, the provider, or utilized available pregabalin from the E-Kit in relation to this medication not being available. A pharmacy email, sent to the facility on 7/22/26 at 3:52 p.m., indicated the following was identified from the pharmacy call logs: •A "Script" was received on 7/21/26 at 9:14 a.m. •A "Call" was received on 7/21/26 at 6:38 p.m.: "checking on status - facility staff informed pregabalin would be on 1st delivery." •"Medication delivered 7/21 at 10:10pm". During an interview on 7/21/2026 at 11:16 p.m., R2 stated she took pregabalin for neuropathy in her feet, but it had not been working as well lately. In the past she did not have pain or tingling in her feet but now she does. R2 was currently utilizing an opioid pain medication that relieves the pain but not the tingling. R3: R3's provider order dated 7/14/26 instructed pregabalin give 150 mg by mouth three times a day for pain. R3's BIMS dated 7/16/26 indicated moderately impaired cognition. R3's diagnoses list dated 7/21/26 included encephalopathy, aspiration pneumonia, acute respiratory failure and hypertension. R3's MAR for July 2026 identified R3 did not receive			21550			08/21/2026

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21550	Continued from page 4 21 doses of pregabalin from 7/14/26 through 7/21/26 as indicated by a documented “9.” R3’s nursing notes dated 7/14/26 through 7/21/26 identified the pregabalin tablets were “not available”, “medication not delivered by pharmacy, will f/u”, “medication not on hand”, “waiting on pharmacy new resident”, “waiting on order”, “med not available. Nurse notified”, and “medication not here charge nurse called pharmacy and it will be delivered tonight”. A pharmacy email, sent to the facility on 7/22/26 at 3:52 p.m., indicated the following calls from the facility were found on the pharmacy call logs: •Call received 7/15/26 at 12:51 a.m.: the tech informed facility staff that they did not receive scripts with admission. •Script received 7/18/26 at 10:20 a.m.: patient name and date of birth (DOB) on the script did not match what was on file wih the pharmacy. •Call received 7/20/26 at 7:57 p.m.: the tech informed facility staff that they still had not received a script for pregabalin. "I believe this is because of the mismatched name spelling and DOB." •Call received 7/21/26 at 4:52 p.m.: checking on status - facility staff informed pregabalin would be on 1st delivery. •Call received 7/21/26 at 7:16 p.m.: E-Kit code requested for Lyrica (pregabalin). •On 7/21/26, at 10:10 p.m., the medication was delivered During an interview on 7/21/2026 at 1:31 p.m., R3 stated he had neuropathy that made his feet very tingly. Usually, the pregabalin took the tingling away, but right now the tingling has been bad. R3 thought he was taking pregabalin but could not remember if he took it that morning. During an interview on 7/21/2026 at 1:39 p.m., trained medication assistant (TMA)-A stated that if a medication was not in the medication cart, he would look for it in the medication room. If the medication was not in the medication room, he would notify the nurse and document that the medication was			21550			08/21/2026

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21550	Continued from page 5 unavailable and that the nurse had been notified. During an interview on 7/21/2026 at 3:53 p.m. TMA-B stated if a medication was not in the medication cart, she would look for it in the medication room. If the medication was not in the medication room, she would notify the nurse and document that the medication was unavailable. During an interview on 7/21/2026 at 2:20 p.m., licensed practical nurse (LPN)-A stated a nurse needed to reorder any controlled medications. The TMA would notify the nurse when the medication was getting low. The nurse would contact the pharmacy to see if any refills remained. If the medication required a new order, the nurse would contact the provider for an order. If there was an active order, the nurse could obtain a code for the E-Kit from the pharmacy so the medication could be administered at the correct time. LPN-A did not recall if she was notified about R2 or R3's pregabalin. During an interview on 7/21/2026 at 2:39 p.m., the pharmacist (Pharm-D) stated when the pharmacy needs a prescription for a medication, they will put the information into the electronic record and pharmacy dashboard. The order will be flagged as needing a prescription. Pharm-D stated the pharmacy did not receive a prescription for R2's pregabalin until 7/21/26. Pharm-D confirmed there was no communication from the facility regarding R2's pregabalin. Pharm-D stated they received a prescription for R3's pregabalin on 7/18/26 but R3's date of birth was incorrect. Pharm-D stated there were notifications to the facility about contacting the provider to correct the date of birth, but the pharmacy did not receive the corrected prescription until 7/21/26. Pharm-D confirmed the facility had pregabalin in the e-kit, but the facility had not contacted pharmacy for the code required to access the E-Kit. During an interview on 7/21/2026 at 4:09 p.m., the director of nursing (DON) stated a TMA would alert the nurse if a medication was unavailable. The nurse would contact the pharmacy to see why the medication had not been sent. The nurse should request a code for the E-Kit if the resident had a current prescription or should contact the provider for a new prescription. The nurse should document calling the pharmacy and any provided information			21550			08/21/2026

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21550	Continued from page 6 as well as if the provider was notified about needing a prescription and/or the resident not receiving ordered medication. The nurse manager and DON had access to the pharmacy dashboard where communication was placed from pharmacy about medication that had been reordered, medications that were ordered too early, medications that were being sent in the next delivery, medications that needed new prescriptions and other information about medication. DON stated she had just found out R2 and R3 had not been receiving their ordered pregabalin and confirmed there were no notes written by a nurse about contacting the pharmacy or provider. DON stated all residents should receive their ordered medications so they can be stable and free of pain. A call was placed to nurse practitioner on 7/21/2026 at 3:27 p.m. with no return phone call. The Medication administration policy dated 6/12/24 instructed medications to be administered as ordered by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on emergency medication use from the onsite emergency kit (E-Kit) and educate floor staff, then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days			21550			08/21/2026