Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
May 30, 2025

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

RE: CCN: 245290
Cycle Start Date: April 9, 2025

Dear Administrator:

On May 12, 2025, 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 May 12, 2025, 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(ies) listed below to the CMS location for imposition. The CMS location 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 May 14, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective May 14, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 14, 2025, (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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 9, 2025. This prohibition is not subject to appeal. 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.

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. <u>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.</u>

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 April 9, 2025. 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 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 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 October 9, 2025 (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.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to 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)

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 30, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 0YD911

Dear Administrator:

The above facility was surveyed on May 7, 2025 through May 12, 2025 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 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 05/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 5/7/25, 5/8/25, and 5/12/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ (F689) began on 5/5/25 when R1 left the facility and was found by a community member several blocks away confused, and returned to the facility by local police. The administrator, and director of nursing (DON) were notified of the IJ on 5/8/25 at 5:10 p.m. The IJ was removed on 5/12/25.

The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/12/25.

The following complaints were reviewed: H52904209C (MN00112851 and MN00112853) with a deficiency cited at F689, F609, and F610. .

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/05/2025

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse, Neglect, and Exploitation and Elopements and Wandering	F 607	Immediate action(s) taken for the resident (s) found to have been affected include: A thorough investigation was	6/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 2 Resident policy for 1 of 3 (R1) residents reviewed for elopement. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/23/25, indicated R1 had moderate cognitive impairment, was independent with activities of daily living and mobility, did not have any behaviors of wandering, exit seeking, and did not wear any exit alarms. During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a wanderguard on his left ankle under his sock. R1 indicated a couple of days prior he was able to "flee" the facility and was gone for about an hour before the "cops busted" him and made him go back to the facility. R1 further identified, he used a fingernail file to cut his "bracelet" (wanderguard) off his ankle; had breakfast, no one had noticed his "bracelet" was off and he watched the door until no one was watching; he pushed the door open, and stated, he "seized the opportunity." R1 stated he intended to walk to a neighboring town about thirty miles away to a place where he knew a friend would be, and then get the friend to take him home. R1 further stated he did not like being in the facility, and had no intention of ever returning to the facility, but the "cops" made him go back. R1 further identified the facility put another bracelet on his ankle to keep him in, but he had gotten out before and was planning to attempt it again. But the next time he would bring a club so no one could get close enough to take him back to the facility. R1 further explained a couple of months prior he had cut his wanderguard off and got out. He stated he was gone for about 20 minutes before the staff	F 607	conducted by the Director of Nursing Services or designee(s) regarding the elopement made by resident #R1. Results of the investigation were reported to the State Survey Agency. 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: The policy for reporting allegations of abuse/neglect/exploitation was reviewed and revised to ensure compliance with current state and federal regulations. An in-service education program was conducted by the Director of Nursing Services and designee with all staff regarding this new policy. All staff was educated on notifying Director of Nursing Services, Administrator or designee of reported allegations of abuse/neglect/exploitation to be filed to appropriate agencies. How the corrective action(s) will be monitored to ensure the practice will not reoccur: A thorough investigation of any allegation will be conducted, and findings will be reported to the appropriate agencies in accordance with current facility policy. The Director of Nursing Services, or designee, will interview five (5) employees weekly for four (4) consecutive weeks to verify understanding of current policy for reporting allegations of abuse/neglect/exploitation.	

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F 607

Continued From page 3

noticed. R1 then stated, "They don't like me here, I am trouble, and I am very angry about having to be here [in the facility]."

R1's medical record was reviewed and lacked any documentation related to the reported elopement attempts.

Review of facility incident reports did not include any risk management, incident reports, or investigations related to the reported elopement attempts.

The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R1's reported elopement attempts on 2/23/25 or 5/5/25.

During an interview on 5/7/25 at 1:10 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and not able to be outside without staff. On 5/5/25, staff last saw R1 eating breakfast, but not sure what time that was. When NA-B was going to administer his medications, she could not find him. Staff searched the facility, and police called in to say someone in the community found him and called them. R1 wears a wanderguard and cannot go outside alone but stated, "He [R1] is sneaky" and will sit by the door until another resident goes out and try to get out with them."

During an interview on 5/7/25 at 1:45 p.m., NA-B stated on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him. She noted R1's walker to be parked by the front door. The director of nursing (DON) got a phone call about 8:50a.m. - 8:55 a.m. that someone had found R1

F 607

Re-education will be provided at the time of the interview, if needed. All Incident reports and grievances will be reviewed by Administrator and DON for identification for abuse. Incident reports and Grievances will be reviewed with IDT on the next IDT meeting date. Review of reporting requirements will be reviewed at the time of identification of needing to report. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people.

Summary of investigations, interviews, and incidence of re-education, if required, will be discussed with the IDT at monthly Quality Assurance meeting. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607		F 607		

Continued From page 4
on the other side of town and called the police. NA-B sated R1 had gotten "very, very, very far" from the facility and it was a long way to walk.

During an interview on 5/7/25 at 3:07 p.m., regisitred nurse (RN)-B stated on 5/5/25, R1 was at breakfast and "all of a sudden he was gone." R1 talked to her when he returned and was upset. R1 explained to RN-B that he wanted to get home, so he went downtown and crossed the highway with the intention to walking to his hometown. RN-B further identified R1 had been planning this [elopement] and watched the door until no one was around and "booked it." RN-B identified she did not know if the facility filed a report to the SA.

During an interview on 5/8/25 at 10:47 a.m., community member (CM) stated on 5/5/25 at approximately 8:45 a.m., she noted an elderly gentleman, later identified as R1, walking in a residential area about a block away from a major highway. CM stated R1 "looked lost" and approached him as he was crossing the street. CM further stated R1 "was determined to get to Fairfax [neighboring town about 30 miles away] by walking along that highway." The CM walked about a block visiting with R1, and learned that he was a resident of the facility and did not intend to go back to the facility. The CM then stepped away to call the police department and they were unaware of any missing persons from the facility. The CM identified the residential neighborhood that R1 was found in was about 12 blocks from the facility, and the route included crossing over a busy major highway and a railroad track, and R1 wanted to get to another highway to walk thirty miles to his destination.

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	245290	A. BUILDING ______ B. WING ______	C 05/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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During an interview on 5/9/25 at 2:35 p.m., police officer (PO) stated on 5/5/25 at 8:50 a.m., the police department received a call that an elderly man (identified as R1) was walking about 12 blocks away from the facility while attempting to walk to Fairfax. The PO also indicated R1 had eloped from the facility previously on 2/23/25, but the facility found him before the police responded, so the facility cancelled the call. From the police notes, it indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks and footprints in the snow and was able to locate him. No other information was available due to the facility cancelling the call before the officers responded.

The facility polic Abuse, Neglect, and Exploitation dated 4/25/25, defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also identified the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies withing specified timeframes of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury or not later that 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final withing 5 [five] working days of the incident, as required by state agencies.

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During an interview on 5/8/25 at 4:24 p.m., director of nursing (DON) indicated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff that R1 was not in the building. The DON further explained R1 signed his name in the sign-out book but did not have a time or date when he left so they started to get worried about him and the police returned him to the facility shortly after they realized R1 was gone. The DON stated the IDT team "debated" about reporting the elopement to the SA during a meeting on 5/6/25 and it was determined R1 did not elope so did not investigate or report it to the SA. The DON indicated she was not aware of R1's 2/23/25 elopement attempt and did not know if it was investigated or reported to the SA.

During an interview on 5/8/25 at 9:45 a.m., the administrator indicated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. that they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his wanderguard off. The administrator indicated he did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, "it [elopement] wasn't on my radar". The administrator did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the state agency (SA) but the elopement was not investigated or reported and was unaware of any of R1's previous elopements from the facility.

Review of the facility's policy titled, Abuse, Neglect, and Exploitation dated 4/25/25 defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid

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physical harm, pain, mental anguish, or emotional distress. The policy identified the following: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur.
Investigate different types of alleged violations.
Identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.
Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and
Providing complete and thorough documentation of the investigation.
Protection of the Resident to include:
Examining the alleged victim for any sign of injury, including physical examination or psychosocial assessment if needed.
Increased supervision of the alleged victim and residents
Room or staffing changes, if necessary, to protect the residents
Providing emotional support and counseling the resident during and after the investigation, as needed;
Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.
Reporting/Response to include:
the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies withing specified timeframes of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury or not later than 24

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F 607	Continued From page 8 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final withing 5 [five] working days of the incident, as required by state agencies. Take all necessary actions as a result if [of] the investigation, which may include, but are not limited to the following: Analyzing the occurrence(s) to determine why abuse, neglect, occurred and what changes are needed to prevent further recurrences. Defining how care provision will be changed and/or implemented to protect residents receiving services. Training of staff on changes made and demonstration of staff competency after training is implemented. Identification of person responsible for monitoring implementation of the plan. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		6/18/25

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F 609	Continued From page 9 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an elopement from the facility was recognized and reported to the State Agency (SA) for 1 of 1 resident (R1) reviewed for elopement. Findings include: During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a WanderGuard (a bracelet wander management system that ensures resident safety with customizable door access) on his left ankle under his sock. R1 stated a couple of days prior he was able to "flee" the facility, and was gone for about an hour before the "cops busted" him and made	F 609	1. Immediate Correction: Resident #1 was reassessed by the Director of Nursing Services or designee on 5/5/2025 to verify the location and any possible injuries from elopement. The physician and the residents family were notified upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services or designee. 2. All residents have the potential to be affected in this area. 3. Staff Education: An in-service education will be conducted by the Director of Nursing Services or designee	

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him go back to the facility. He used a fingernail file to cut his "bracelet" (WanderGuard) off his ankle; had breakfast, and no one had noticed his bracelet was off. He watched the door until no one was watching, and pushed the front entry door open. "I seized the opportunity and walked out." He intended to walk to a neighboring town about thirty miles away, to a place where he knew a friend would take him home. He did not like being in the facility, and had no intention of ever returning to the facility, but the "cops" made him go back. The facility put another bracelet on his ankle to keep him in, but he had gotten out before, and was planning to attempt it again. The next time he would "bring a club so no one could get close enough to take me back to the facility." A couple of months prior, he had cut off his WanderGuard and gotten out of the facility. He was gone for about 20 minutes and made it about 8 blocks in the snow before the staff noticed he was gone.

R1's medical record was reviewed and lacked any documentation related to the reported elopement attempts.

Review of facility incident reports lacked any risk management or incident reports related to the reported elopement attempts.

The Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R1's reported elopement attempts on 2/23/25 or 5/5/25.

R1's Elopement Risk Assessment dated 4/22/25 indicated R1 was at risk for elopement related to his habit of wandering or attempting to leave the building, asking to go home or other specific

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with all staff addressing circumstances that require reporting including appropriate timeframes.

4. The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. Also, All Incident reports and grievances will be reviewed by Administrator and DON for identification for abuse. Incident reports and Grievances will be reviewed with IDT on the next IDT meeting date. Review of reporting requirements will be reviewed at the time of identification of needing to report. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. Summary of incident reports and grievances and findings will be discussed with the IDT at monthly Quality Assurance meeting. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

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destinations, diagnoses of dementia, and eloping from this setting or a previous setting. Other risks included R1's family voicing concerns he may have a tendency to wander or elope, and he took medications that could cause confusion. Interventions implemented were recreational activities of interest, check in and out log, staff awareness of elopement risk, personalization of room and WanderGuard in place on R1's ankle.

During an interview on 5/7/25 at 1:10 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and not able to be outside without staff. On 5/5/25, R1 was last seen eating breakfast and when NA-B was going to administer his medications, she could not find him. A search of the facility was done, and police called in to say someone in the community had found R1 and called them. R1 wore a WanderGuard and could not go outside alone but "he is sneaky" and "will sit by the door until another resident goes out and try to get out with them."

During an interview on 5/7/25 at 1:45 p.m., NA-B stated on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him. She noted R1's walker to be parked by the front door. The director of nursing (DON) received a phone call about 8:50 a.m. to 8:55 a.m. which said someone had found R1 on the other side of town, and called the police. R1 had gotten "very, very, very far" from the facility, and it was a long way to walk.

During an interview on 5/7/25 at 3:07 p.m., RN-B stated on 5/5/25 R1 was at breakfast and "all of a sudden he was gone." R1 talked to her when he

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returned, and he was upset. He explained to her he wanted to get home, so he went downtown and crossed the highway with the intention to walking to his hometown. R1 had been planning this [elopement] and watched the door until no one was around and "booked it." She did not know if the facility filed a report to the SA.

During an interview on 5/8/25 at 4:24 p.m., the DON stated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff R1 was not in the building. R1 signed his name in the sign-out book, but did not have a time or date when he left. They started to get worried about him, and the police returned him to the facility shortly after they realized he was gone. The IDT team "debated" about reporting the elopement to the SA during a meeting on 5/6/25, and it was determined R1 did not elope, so it was not reported. She was not aware of R1's 2/23/25 elopement attempt, and did not know if a report to the SA was filed.

During an interview on 5/8/25 at 9:45 a.m., the administrator stated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his WanderGuard off. He did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, "it [elopement] wasn't on my radar." He did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the SA, but the elopement was not reported. He was unaware of any of R1's previous elopements from the facility, and did not know if nursing did an assessment to determine if R1 was safe to be outside unsupervised.

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	The undated facility policy Elopement and Wandering Residents defined elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Compliance guidelines include alarms are not a replacement for necessary supervision.			
	The facility policy Abuse, Neglect, and Exploitation dated 4/25/25, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also identified the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies within specified time frames of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final within 5 [five] working days of the incident, as required by state agencies.			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/18/25
	§483.25(d) Accidents. The facility must ensure that -			

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F 689	Continued From page 14 §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 observation, interview, and document review, the facility failed to comprehensively assess supervision needs, develop individualized person-centered interventions to mitigate risks and hazards for 1 of 3 residents (R1) reviewed for elopement risk. This resulted in an immediate jeopardy (IJ) when R1 left the facilty without staff knowledge and was found 12 blocks away, unharmed by a community member. The immediate jeopardy began on 5/5/25 when R1 left the facility and was found by a community member several blocks away confused, and returned to the facility by local police. The IJ was identified on 5/8/25. The administrator, director of nursing (DON), director of operations, and director of clinical operations were notified of the immediate jeopardy on 5/8/25 at 5:10 p.m. The immediate jeopardy was removed on 5/12/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's hospital Discharge Placement Referral dated 1/14/25, indicated R1 required long term care placement due to not being safe or able to care for self at home. The referral further indicated R1's memory is poor, thinking is	F 689	1. Immediate Correction: The facility reviewed policies of Out on Leave and Missing Person/Elopement Policy. The facility will review the resident R1 for a Safety Plan through determination of an elopement risk assessment and a SLUMs assessment. Occupational therapy will help determine if an Allan cognitive test will be needed per SLUMs score. After determination of the scores, the assessment will be review by IDT. These assessments will help determine the level of supervision and Immediate interventions implemented for R1 in concern include 1 to 1 supervision through 5/12/25. Nursing department will be checking his wander guard per protocol and not to provide any sharp objects. Long-term interventions will be put in place through evaluation of the assessments to determine if there is a concern and what staff should do to mitigate the risk. 2. Facility reviewed elopement assessments of all residents. 8 Residents were identified and reviewed. Care plans reviewed for appropriate interventions. Care plans were reviewed and revised. 3. Staff Education: DON or designee will	

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F 689	Continued From page 15 delusional, and family was in the process of getting power of attorney and working with Adult Protective Services on placement. R1's Medical Diagnoses report dated 1/15/25, identified R1 had diagnoses of lumbar spondylosis (degeneration of the lumbar spine), disorientation, moderate dementia with behavioral disturbance, hypertension, weakness, right shoulder arthritis, and macular degeneration (medical condition that causes blurred vision or no vision in the center field). R1's Care Plan Report focus initiated 1/17/25, identified R1 has moderate dementia with behavioral disturbance and was an elopement risk/wanderer related to impaired safety awareness. Intervention history included on 2/4/25, Wanderguard was placed on R1's right ankle to alert staff if attempting to leave the building on his own; on 4/17/25, Wanderguard placed on R1's walker. In review of R1's record between 1/17/25 through 4/17/25, the record did not include an assessment or notation of rationale for the implementation of the Wanderguard that was placed on 2/4/25 on R1's right ankle nor why it was changed to his walker on 4/17/25. During an interview on 5/9/25 at 2:35 p.m., police officer (PO) indicated R1 had eloped from the facility previously on 2/23/25 but the facility found him before the police responded so the facility cancelled the call. PO stated the report indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks in the snow and were able to locate him. No other information was available due to the call being cancelled by	F 689	educate staff on procedures pertaining to residents leaving the facility, missing persons, elopement, and wander guard system. Nurses will receive education on comprehensively assessing and reviewing residents for safety in regard to elopements, falls, and cognitive impairment. Staff will be notified via text message to complete education and the test by their next on coming shift. Education will be sent out on 5/9/25. The Director of Nursing Services, or designee, will interview five (5) employees weekly for four (4) consecutive weeks for one (1) month then every other week for two (2) months to verify understanding of procedures pertaining to residents leaving the facility, missing persons, elopement and wander guard system. Interviews will be documented as completed with each staff member; signed and dated by staff member and interviewer. 4. The Quality Assurance and Performance Improvement (QAPI) committee will review the interview results completed by staff members and compliance with the established system to ensure ongoing compliance, monthly and adjust as necessary. This POC aims to ensure resident safety by minimizing the risk of elopement accidents related to smoking, in compliance with F Tag 689. Staff will report any missing residents immediately to DON or designee and this information will be presented in QAA on a monthly basis to determine if further interventions will be needed.	

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the facility.

Review of R1's record did not identify an accounting of this incident, nor were there updated interventions reflected in the care plan after R1 eloped in February 2025. Further there was no indication the facility completed an incident report with an investigation.

R1's Fall Risk Assessment dated 4/22/25, indicated R1 was at high risk for falls due to R1's intermittent confusion, balance problem while walking and standing, use of assistive devices, and took three to four high risk medications.

R1's ROM (range of motion) and Mobility assessment dated 4/22/25, identified R1 had impairment of one upper extremity, was steady with walking at all times, and used a walker.

R1's Elopement Risk Assessment dated 4/22/25, indicated R1 was at risk for elopement related to R1's habit of wandering or attempting to leave the building, asking to go home or other specific destinations, diagnoses of dementia, eloping from this setting or a previous setting. R1's family voicing concerns that the resident may have a tendency to wander or elope, and taking medications that could cause confusion. Interventions implemented were recreational activities of interest, check in and out log, staff awareness of elopement risk, personalization of room and Wanderguard (bracelet wander management system that ensures resident safety with customizable door access) in place on R1's ankle.

R1's quarterly Minimum Data Set (MDS) dated 4/23/25, indicated R1 had moderate cognitive

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impairment, was independent with activities of daily living and mobility, did not have any behaviors of wandering, exit seeking, and did not wear any exit alarms even though the facility elopement assessment identifed R1 was at risk and had a wanderguard alarm.

R1's progress notes dated 5/1/25, at 11:56 a.m., R1 was exit seeking in the morning, stating he wanted to go home, needed to go to the bank. At 10:00 a.m., had coat on and attempted to leave facility when another resident opened the front door. Staff redirected and told social service designee (SSD). R1 stated he was going to walk to the (out of town] bank. R1 did have a Wanderguard on and door did lock when resident was walking to chair by front entry.

Review of R1's record did not include a comprehensive assessment of R1's risk for elopement for appropriate interventions including level of supervision following the elopement attempt on 5/1/25. Further, no indication R1's care plan interventions were re-evaluated for effectiveness and/or new interventions were developed and implemented to prevent or mitigate the risk for R1 to elope. In addition, R1's record did not include a comprehensive cognitive assessment that would identify R1's functional capacity for safe decision making and/or identify R1's ability to be safe in the community independently.

A vulnerable adult report submitted to the State Agency dated 5/6/25 indicated on the morning on 5/5/25 R1 had been walking on a sidewalk looking lost as he crossed an intersection. R1 had planned to walk back to his home (approximately 30 miles away). Local law enforcement was

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contacted.

Review of Facility event/incidents reports did not include a report nor an investigation for R1's elopement on 5/5/25. Furthermore, there was no accounting of the elopement in R1's record nor evident a comprehensive assessment completed and there was no care plan updates/revisions prior to the start of the survey on 5/7/25.

During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a Wanderguard on his left ankle under his sock. R1 indicated a couple of days ago (5/5/25) he was able to "flee" the facility and was gone for about an hour before the "cops busted" him and made him go back to the facility. R1 used a fingernail file to cut his "bracelet" (Wanderguard) off his ankle and went for breakfast. No one had noticed his bracelet was off. He watched the door until no one was watching, he pushed the door open, and "seized the opportunity". R1 had intended to walk to a neighboring town about thirty miles away to a place where he knew a friend would be and then get the friend to take him home. R1 did not like being in the facility and had no intention of ever returning to the facility, but the "cops" made him go back. Then the facility put another bracelet on his ankle to keep him in, but he had gotten out before and was planning to attempt it again. The next time he would bring a club so no one could get close enough to take him back to the facility. R1 further explained a couple of months prior he had cut his Wanderguard off and got out and that time he was gone for about 20 minutes before the staff noticed. R1 then stated, "they don't like me here, I am trouble, and I am very angry about having to be here [in the facility]".

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During an interview on 5/8/25 at 10:47 a.m., community member (CM) indicated on 5/5/25 at approximately 8:45 a.m., she noted an elderly gentleman, later identified as R1, walking in a residential area about a block away from a major highway. CM stated, R1 "looked lost" and approached him as he was crossing the street. CM further indicated R1 "was determined to get to Fairfax [neighboring town about 30 miles away] by walking along that highway". The CM walked about a block visiting with R1 and learned that he was a resident of the facility and did not intend to go back to the facility. CM then called the police, and they were unaware of any missing persons from the facility. CM identified the residential neighborhood that R1 was found in was about 12 blocks from the facility and the route included crossing over a busy major highway and a railroad tracks.

During an interview on 5/9/25 at 2:35 p.m., police officer (PO) identified on 5/5/25 at 8:50 a.m., the police department received a call that an elderly man (identified as R1) walking about 12 blocks away from the facility while attempting to walk to Fairfax. R1 did not want to go back to the nursing home but, the PO did not feel R1 was safe to be walking in the community without his walker. R1 would have had to cross the railroad tracks and the major highway to get to that location he was found at.

During an interview on 5/8/25 at 8:45 a.m., family member (FM)-A denied notification by the facility of R1's elopement on 5/5/25 and this was her first knowledge of the incident. FM-A stated, "I am not surprised, it's not his first time escaping the facility." FM-A indicated the first time R1 eloped, it was winter, and staff found him about 7-8

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blocks from the facility and further stated, "he [R1] is absolutely not safe to be out of the building [facility] on his own". FM-A identified R1 was admitted to the facility because he was having delusional thoughts, paranoia, and erratic behavior due to his dementia. R1 was not safe to live independently anymore and needed 24-hour supervision.

During an interview on 5/7/25 at 12:40 p.m., nursing assistant (NA-C) indicated R1 was not safe to go outside without staff supervision. R1 liked to sit by the front entry and when a family member or another resident went outside, R1 would go out too and staff would bring him back in.

During an interview on 5/7/25 at 1:10 p.m., NA-A, indicated R1 was an elopement risk and not able to be outside without staff. R1 wore a Wanderguard and cannot go outside alone but stated, "he [R1] is sneaky" and would sit by the door until another resident went out and would try to get out with them." On 5/5/25, R1 was last seen eating breakfast but not sure what time that was. When NA-B was going to administer his medications, she could not find him. A search of the facility was done. The police called the facility to inform them R1 was found by someone in the community.

During an interview on 5/7/25 at 1:45 p.m., NA-B identified on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him but noted R1's walker to be parked by the front door. The director of nursing got a phone call at 8:50am - 8:55 a.m. that someone had found R1 on the other side of town and called the police. NA-B

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further stated R1 was an elopement risk and had a Wanderguard bracelet on but did not have the Wanderguard on him when the police brought him back. NA-B stated two nail clippers were found in R1's room so he must have cut off his Wanderguard "again." NA-B further explained R1 had "almost" cut it off on the evening shift a while ago but could not recall when it happened. NA-B sated R1 had gotten "very, very, very far" from the facility this last time and it was a long way to walk.

During an interview on 5/7/25 at 1:19 p.m., licensed practical nurse (LPN)-A, indicated the morning of 5/5/25, maintenance staff told her R1 was "gone and we needed to look for him." LPN-A could not remember the time this was reported to her. LPN-A identified R1 wore a Wanderguard which meant he had to be supervised if he goes out of the facility. The police returned R1 to the facility and R1 was on 15-minute checks but was not sure where those checks were documented or who did them.

During an interview on 5/7/25 at 2:00 p.m., registered nurse (RN)-A indicated she was not in the facility when R1 eloped on 5/5/25 but interdisciplinary team (IDT) discussed the incident on 5/6/25 and a Wanderguard had been put back on R1. RN-A indicated R1 always wanted to go home but was an elopement risk and not safe to go outside without supervision.

During an interview on 5/7/25 at 2:20 p.m., health unit coordinator (HUC) indicated on 5/5/25 at approximately 8:10 a.m. the DON told him to look for R1, so he drove his car around town to try to find him, but the police brought R1 back. HUC further identified R1 was an elopement risk and

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could not go outside independently so R1 wore a Wanderguard so the doors would alarm if he left the facility.

During an interview on 5/7/25 at 3:07 p.m., RN-B indicated on 5/5/25, R1 was at breakfast and, "all of a sudden he was gone." R1 talked to her when he returned to the facility, he was very upset. R1 explained to RN-B that he wanted to get home so he went downtown and crossed the highway with the intention to walk to his hometown. RN-B further identified R1 had been planning this [elopement] and watched the door until no one was around and "booked it". The only intervention that was communicated after the elopement was that another Wanderguard was placed on R1's ankle and some forks and a razor were taken out of his room.

During an interview on 5/8/25 at 4:18 p.m., NA- D identified R1 could not go outside unsupervised because R1 was not safe alone in the community because he may fall with no one around to help.

During an interview on 5/8/25 at 4:28 p.m., NA-E indicated R1 can go outside only if staff are with him because if R1 were to go outside by himself, he could take off again and get confused, dehydrated, or get hit by a car.

During an interview on 5/8/25 at 4:52 p.m., NA-G indicated R1 has a Wanderguard bracelet on his ankle which meant he could not go outside without staff. R1 was not safe to go outside, he could elope again and not be found.

During an interview on 5/8/25 at 1:45 a.m., the social service designee (SSD) indicated R1 signed his name in the sign out book, so SSD did

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not consider R1 leaving the facility unsupervised and without staff knowledge an elopement. SSD identified R1 as an elopement risk but did not consider him a high elopement risk and stated, "everyone in the facility is an elopement risk". The SSD then indicated she did not know whether R1 had an assessment completed to determine if he was safe in the community without supervision and did not know why R1 wore a Wanderguard. The SSD said R1 has the right to be out in the community and he had intentions of returning to his hometown to be on the planning committee for the hometown celebration and parade. SSD stated it was not safe for anyone to walk the highway, not even herself.

During an interview on 5/8/25 at 4:24 p.m., director of nursing (DON) indicated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff that R1 was not in the building. The DON further explained R1 signed his name in the sign-out book but did not have a time or date when he left so they started to get worried about him and the police returned him to the facility shortly after they realized R1 was gone. The DON stated the IDT team "debated" about it during a meeting on 5/6/25 and it was determined R1 had a BIMS (brief interview for mental status) of 12 [moderately impaired cognition], was able to make his needs known, signed out in the book so did not feel it was an elopement. The Wanderguard was just to alert staff that he was going outside by himself because he will try to leave without signing out approximately monthly. The DON indicated the IDT has debated on whether R1 was safe to be outside on his own and it was not clear. DON indicated there was not an assessment completed to determine if R1 was safe in the community without supervision.

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During an interview on 5/8/25 at 9:45 a.m., the administrator indicated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. that they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his Wanderguard off but he could sign himself out and go out of the facility independently. Administrator indicated he did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, "it [elopement] wasn't on my radar". The administrator indicated he did not know the details of R1 getting out of the facility unnoticed, but they removed the fingernail clippers from R1's room, changed the door code, and have the front door always locked now. The administrator did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the state agency (SA) but the elopement was not reported and was unaware of any of R1's previous elopements from the facility and did not know if nursing did an assessment to determine if R1 was safe to be outside unsupervised.

The undated facility policy titled Elopement and Wandering Residents, included the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy defines elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Compliance

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F 689	Continued From page 25 guidelines include alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Procedure post-elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative. c. A social service designee will re-assess the resident and make any referrals for counseling or	F 689		

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F 689	Continued From page 26 psychological/psychiatric consults. d. The resident and family/authorized representative will be included in the plan of care. e. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. g. Documentation in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. The immediate jeopardy that began on 5/5/25, was removed on 5/12/25, when the facility reviewed R1 for a Safety Plan through determination of an elopement risk assessment and a SLUMS; review by IDT, R1 received 1:1 staff supervision; R4 remained in the facility until cognitive and safety assessments and interventions had been determined and a safety plan implemented; reviewed elopement assessments of all residents; care plan were reviewed for appropriate interventions; resident care plans reviewed and revised; DON or designee educated staff on procedures pertaining to residents leaving the facility, missing persons, elopement, and Wanderguard system; nurses received education on comprehensively assessing and reviewing residents for safety in regards to elopement, falls, and cognitive impairment prior to working their next shift. , but the noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689		

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/7/25, 5/8/25, and 5/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaints were reviewed: H52904209C (MN00112851 and MN00112853).	2 000		

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2 000	Continued From page 1 Licensing orders were issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess supervision needs and develop individualized person-centered interventions to identify and mitigate risks and hazards for residents at risk for elopement and when out in the community. This failure resulted in the risk of serious harm, injury, or impairment for 1 of 3	2 830	Corrected	5/12/25

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residents (R1) reviewed for safety.

The immediate jeopardy began on 5/5/25 when R1 left the facility without staff awareness, found by a community member several blocks away confused, and returned to the facility by local police. The IJ was identified on 5/8/25. The administrator, director of nursing (DON), director of operations, and director of clinical operations were notified of the immediate jeopardy on 5/8/25 at 5:10 p.m. The immediate jeopardy was removed on 5/12/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's hospital Discharge Placement Referral dated 1/14/25, indicated R1 required long term care placement due to not being safe or able to care for self at home. The referral further indicated R1's memory is poor, thinking is delusional, and family was in the process of getting power of attorney and working with Adult Protective Services on placement.

R1's Medical Diagnoses report dated 1/15/25, identified R1 had diagnoses of lumbar spondylosis (degeneration of the lumbar spine), disorientation, moderate dementia with behavioral disturbance, hypertension, weakness, right shoulder arthritis, and macular degeneration (medical condition that causes blurred vision or no vision in the center field).

R1's Care Plan Report focus initiated 1/17/25, identified R1 has moderate dementia with behavioral disturbance and was an elopement

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risk/wanderer related to impaired safety awareness. Intervention history included on 2/4/25, Wanderguard was placed on R1's right ankle to alert staff if attempting to leave the building on his own; on 4/17/25, Wanderguard placed on R1's walker.

In review of R1's record between 1/17/25 through 2/4/25, the record did not include an assessment or notation of rationale for the implementation of the Wanderguard that was placed on 2/4/25 on R1's right ankle nor why it was changed to his walker on 4/17/25.

During an interview on 5/9/25 at 2:35 p.m., police officer (PO) indicated R1 had eloped from the facility previously on 2/23/25 but the facility found him before the police responded so the facility cancelled the call. PO stated the report indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks in the snow and were able to locate him. No other information was available due to the call being cancelled by the facility.

Review of R1's record did not identify an accounting of this incident, nor were there new interventions reflected in the care plan after R1 eloped. Further there was no indication the facility completed an incident report with an investigation.

R1's Fall Risk Assessment dated 4/22/25, indicated R1 was at high risk for falls due to R1's intermittent confusion, balance problem while walking and standing, use of assistive devices, and took three to four high risk medications.

R1's ROM (range of motion) and Mobility assessment dated 4/22/25, identified R1 had

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impairment of one upper extremity, was steady with walking at all times, and used a walker.

R1's Elopement Risk Assessment dated 4/22/25, indicated R1 was at risk for elopement related to R1's habit of wandering or attempting to leave the building, asking to go home or other specific destinations, diagnoses of dementia, eloping from this setting or a previous setting, R1's family voicing concerns that the resident may have a tendency to wander or elope, and taking medications that could cause confusion. Interventions implemented were recreational activities of interest, check in and out log, staff awareness of elopement risk, personalization of room and Wanderguard (bracelet wander management system that ensures resident safety with customizable door access) in place on R1's ankle.

R1's quarterly Minimum Data Set (MDS) dated 4/23/25, indicated R1 had moderate cognitive impairment, was independent with activities of daily living and mobility, did not have any behaviors of wandering, exit seeking, and did not wear any exit alarms.

R1's progress notes dated 5/1/25, at 11:56 a.m., R1 was exit seeking in the morning, stating he wanted to go home, needed to go to the bank. At 10:00 a.m., had coat on and attempted to leave facility when another resident opened the front door. Staff redirected and told social service designee (SSD). R1 stated he was going to walk to the (out of town] bank. R1 did have a Wanderguard on and door did lock when resident was walking to chair by front entry.

Review of R1's record between 1/15/25 through 5/5/25 indicated although R1 had exit seeking

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2 830	Continued From page 5 behaviors on 5/1/25 the record did not include a comprehensive reevaluation of R1's risk for elopement for appropriate interventions including level of supervision. Further, no indication R1's care plan interventions were re-evaluated for effectiveness and/or new interventions were developed and implemented to prevent or mitigate the risk for R1 to elope. In addition, R1's record did not include a comprehensive cognitive assessment that would identify R1's functional capacity for safe decision making and/or identify R1's ability to be safe in the community independently. A vulnerable adult report submitted to the State Agency dated 5/6/25 indicated on the morning on 5/5/25 R1 had been walking on a sidewalk looking lost as he crossed an intersection. R1 had planned to walk back to his home (approximately 30 miles away). Local law enforcement was contacted. Review of Facility event/incidents reports did not include a report nor an investigation for R1's elopement on 5/5/25. Furthermore, there was no accounting of the elopement in R1's record nor evident a comprehensive assessment completed and there was no care plan updates/revisions prior to the start of the survey on 5/7/25. During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a Wanderguard on his left ankle under his sock. R1 indicated a couple of days ago (5/5/25) he was able to "flee" the facility and was gone for about an hour before the "cops busted" him and made him go back to the facility. R1 used a fingernail file to cut his "bracelet" (Wanderguard) off his ankle and went for breakfast. Noone had noticed his bracelet was off. He watched the door until no	2 830		

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one was watching, he pushed the door open, and "seized the opportunity". R1 had intended to walk to a neighboring town about thirty miles away to a place where he knew a friend would be and then get the friend to take him home. R1 did not like being in the facility and had no intention of ever returning to the facility, but the "cops" made him go back. Then the facility put another bracelet on his ankle to keep him in, but he had gotten out before and was planning to attempt it again. The next time he would bring a club so no one could get close enough to take him back to the facility. R1 further explained a couple of months prior he had cut his Wanderguard off and got out and that time he was gone for about 20 minutes before the staff noticed. R1 then stated, "they don't like me here, I am trouble, and I am very angry about having to be here [in the facility]".

During an interview on 5/8/25 at 10:47 a.m., community member (CM) indicated on 5/5/25 at approximately 8:45 a.m., she noted an elderly gentleman, later identified as R1, walking in a residential area about a block away from a major highway. CM stated, R1 "looked lost" and approached him as he was crossing the street. CM further indicated R1 "was determined to get to Fairfax [neighboring town about 30 miles away] by walking along that highway". The CM walked about a block visiting with R1 and learned that he was a resident of the facility and did not intend to go back to the facility. CM then called the police, and they were unaware of any missing persons from the facility. CM identified the residential neighborhood that R1 was found in was about 12 blocks from the facility and the route included crossing over a busy major highway and a railroad tracks.

During an interview on 5/9/25 at 2:35 p.m., police

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officer (PO) identified on 5/5/25 at 8:50 a.m., the police department received a call that an elderly man (identified as R1) walking about 12 blocks away from the facility while attempting to walk to Fairfax. R1 did not want to go back to the nursing home but, the PO did not feel R1 was safe to be walking in the community without his walker. R1 would have had to cross the railroad tracks and the major highway to get to that location he was found at. The PO also indicated R1 had eloped from the facility previously on 2/23/25 but the facility found him before the police responded so the facility cancelled the call. From the police notes, it indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks and footprints in the snow and was able to locate him. No other information was available due to the call being cancelled by the facility.

During an interview on 5/8/25 at 8:45 a.m., family member (FM)-A denied notification by the facility of R1's elopement on 5/5/25 and this was her first knowledge of the incident. FM-A stated, "I am not surprised, it's not his first time escaping the facility." FM-A indicated the first time R1 eloped, it was winter, and staff found him about 7-8 blocks from the facility and further stated, "he [R1] is absolutely not safe to be out of the building [facility] on his own". FM-A identified R1 was admitted to the facility because he was having delusional thoughts, paranoia, and erratic behavior due to his dementia. R1 was not safe to live independently anymore and needed 24-hour supervision.

During an interview on 5/7/25 at 12:40 p.m., nursing assistant (NA-C) indicated R1 was not safe to go outside without staff supervision. R1 liked to sit by the front entry and when a family member or another resident went outside, R1

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would go out too and staff would bring him back in.

During an interview on 5/7/25 at 1:10 p.m., NA-A, indicated R1 was an elopement risk and not able to be outside without staff. R1 wore a Wanderguard and cannot go outside alone but stated, "he [R1] is sneaky" and would sit by the door until another resident went out and would try to get out with them". On 5/5/25, R1 was last seen eating breakfast but not sure what time that was. When NA-B was going to administer his medications, she could not find him. A search of the facility was done. The police called the facility to inform them R1 was found by someone in the community.

During an interview on 5/7/25 at 1:45 p.m., NA-B identified on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him but noted R1's walker to be parked by the front door. The director of nursing got a phone call at 8:50am - 8:55 a.m. that someone had found R1 on the other side of town and called the police. NA-B further stated R1 was an elopement risk and had a Wanderguard bracelet on but did not have the Wanderguard on him when the police brought him back. NA-B stated two nail clippers were found in R1's room so he must have cut off his Wanderguard "again". NA-B further explained R1 had "almost" cut it off on the evening shift a while ago but could not recall when it happened. NA-B sated R1 had gotten "very, very, very far" from the facility this last time and it was a long way to walk.

During an interview on 5/7/25 at 1:19 p.m., licensed practical nurse (LPN)-A, indicated the morning of 5/5/25, maintenance staff told her R1

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was "gone and we needed to look for him". LPN-A could not remember the time this was reported to her. LPN-A identified R1 wore a Wanderguard which meant he had to be supervised if he goes out of the facility. The police returned R1 to the facility and R1 was on 15-minute checks but was not sure where those checks were documented or who did them.

During an interview on 5/7/25 at 2:00 p.m., registered nurse (RN)-A indicated she was not in the facility when R1 eloped on 5/5/25 but interdisciplinary team (IDT) discussed the incident on 5/6/25 and a Wanderguard had been put back on R1. RN-A indicated R1 always wanted to go home but was an elopement risk and not safe to go outside without supervision.

During an interview on 5/7/25 at 2:20 p.m., health unit coordinator (HUC) indicated on 5/5/25 at approximately 8:10 a.m. the DON told him to look for R1, so he drove his car around town to try to find him, but the police brought R1 back. HUC further identified R1 was an elopement risk and could not go outside independently so R1 wore a Wanderguard so the doors would alarm if he left the facility.

During an interview on 5/7/25 at 3:07 p.m., RN-B indicated on 5/5/25, R1 was at breakfast and, "all of a sudden he was gone". R1 talked to her when he returned to the facility, he was very upset. R1 explained to RN-B that he wanted to get home so he went downtown and crossed the highway with the intention to walk to his hometown. RN-B further identified R1 had been planning this [elopement] and watched the door until no one was around and "booked it". The only intervention that was communicated after the elopement was that another Wanderguard was placed on R1's

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ankle and some forks and a razor were taken out of his room.

During an interview on 5/8/25 at 4:18 p.m., NA- D identified R1 could not go outside unsupervised because R1 was not safe alone in the community because he may fall with no one around to help.

During an interview on 5/8/25 at 4:28 p.m., NA-E indicated R1 can go outside only if staff are with him because if R1 were to go outside by himself, he could take off again and get confused, dehydrated, or get hit by a car.

During an interview on 5/8/25 at 4:52 p.m., NA-G indicated R1 has a Wanderguard bracelet on his ankle which meant he could not go outside without staff. R1 was not safe to go outside, he could elope again and not be found.

During an interview on 5/8/25 at 1:45 a.m., the social service designee (SSD) indicated R1 signed his name in the sign out book, so SSD did not consider R1 leaving the facility unsupervised and without staff knowledge an elopement. SSD identified R1 as an elopement risk but did not consider him a high elopement risk and stated, "everyone in the facility is an elopement risk". The SSD then indicated she did not know whether R1 had an assessment completed to determine if he was safe in the community without supervision and did not know why R1 wore a Wanderguard. The SSD said R1 has the right to be out in the community and he had intentions of returning to his hometown to be on the planning committee for the hometown celebration and parade. SSD stated it was not safe for anyone to walk the highway not even herself.

During an interview on 5/8/25 at 4:24 p.m.,

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2 830	Continued From page 11 director of nursing (DON) indicated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff that R1 was not in the building. The DON further explained R1 signed his name in the sign-out book but did not have a time or date when he left so they started to get worried about him and the police returned him to the facility shortly after they realized R1 was gone. The DON stated the IDT team "debated" about it during a meeting on 5/6/25 and it was determined R1 had a BIMS (brief interview for mental status) of 12 [moderately impaired cognition], was able to make his needs known, signed out in the book so did not feel it was an elopement. The Wanderguard was just to alert staff that he was going outside by himself because he will try to leave without signing out approximately monthly. The DON indicated the IDT has debated on whether R1 was safe to be outside on his own and it was not clear. DON indicated there was not an assessment completed to determine if R1 was safe in the community without supervision. During an interview on 5/8/25 at 9:45 a.m., the administrator indicated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. that they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his Wanderguard off but he could sign himself out and go out of the facility independently. Administrator indicated he did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, "it [elopement] wasn't on my radar". The administrator indicated he did not know the details of R1 getting out of the facility unnoticed, but they removed the fingernail clippers from R1's room, changed the door code, and have the front door always locked now. The administrator did clarify a resident leaving the	2 830		

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facility without staff knowledge would be an elopement and reportable to the state agency (SA) but the elopement was not reported and was unaware of any of R1's previous elopements from the facility and did not know if nursing did an assessment to determine if R1 was safe to be outside unsupervised.

The undated facility policy titled Elopement and Wandering Residents, included the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy defines elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Compliance guidelines include alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.
The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.
Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and
throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00939	A. BUILDING: ____ B. WING ____	C 05/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13	2 830		

Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Procedure post-elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative. c. A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults. d. The resident and family/authorized representative will be included in the plan of care. e. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. g. Documentation in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable.

The immediate jeopardy that began on 5/5/25, was removed on 5/9/25, when the facility reviewed R1 for a Safety Plan through determination of an elopement risk assessment and a SLUMS; review by IDT, R1 received 1:1

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2 830	Continued From page 14 staff supervision; R4 remained in the facility until cognitive and safety assessments and interventions had been determined and a safety plan implemented; reviewed elopement assessments of all residents; care plan were reviewed for appropriate interventions; resident care plans reviewed and revised; DON or designee educated staff on procedures pertaining to residents leaving the facility, missing persons, elopement, and Wanderguard system; nurses received education on comprehensively assessing and reviewing residents for safety in regards to elopement, falls, and cognitive impairment prior to working their next shift. , but the noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision. The director of nursing or designee, should conduct measurable audits to ensure appropriate assessments completed and implementation of the care plan . The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		