



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2025

Administrator
Olivia Hospital & Clinic
1003 West Maple Avenue
Olivia, MN 56277

Re: Reinspection Results
Event ID: 9T7R11

Dear Administrator:

On July 3, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 30, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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

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

RE: CCN: 241306
Cycle Start Date: April 9, 2025

Dear Administrator:

On April 29, 2025, we notified you a remedy was imposed. On July 3, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 26, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 14, 2025, be discontinued as of June 26, 2025. (42 CFR 488.417 (b))

In our letter of April 29, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 14, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads '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
June 16, 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 April 29, 2025, we informed you of imposed enforcement remedies.

On May 30, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 29, 2025, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 14, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 14, 2025.

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.

As we notified you in our letter of April 29, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide

Olivia Restorative Care Center

June 16, 2025

Page 2

Training and/or Competency Evaluation Programs (NATCEP) for two years from April 9, 2025.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 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.

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

- Optional denial of payment for new Medicare and Medicaid admissions

(42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division 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

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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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)

Olivia Restorative Care Center

June 16, 2025

Page 5

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.

A handwritten signature in black ink, appearing to read 'Melissa Poepping', written in a cursive style.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered
June 16, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 9T7R11

Dear Administrator:

The above facility was surveyed on May 27, 2025 through May 30, 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.

Olivia Restorative Care Center

June 16, 2025

Page 2

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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 06/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2025
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NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277
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(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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F 000	<p>INITIAL COMMENTS</p> <p>On 5/27/25 through 5/30/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed:</p> <p>H52905389C (MN00113300) with a deficiency issued at F689.</p> <p>H52905687C (MN00113366).</p> <p>The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 successfully eloped from the building without the alarm sounding, was allowed out of the locked front entrance by a responsible party and was found by community members approximately one mile from the facility an hour later, unharmed. The IJ began on 5/21/25, and the immediacy was removed on 5/29/25.</p> <p>The above findings constituted substandard quality of care, and an extended survey was conducted on 5/29/25 through 5/30/25.</p> <p>In addition, as a result of the investigation additional deficiencies were cited at F550 and F726.</p> <p>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</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/20/2025
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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.

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

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p>	F 550		6/26/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 550	<p>Continued From page 2</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a system to ensure residents who were cognitively intact, and not an elopement risk could freely enter and exit the facility for 1 of 1 residents (R5) reviewed for resident rights.</p> <p>Findings include:</p> <p>R5' Face sheet dated 5/27/25, indicated R5 was admitted to the facility on 5/23/25 and his diagnoses included osteonecrosis (death of bone tissue due to a lack of blood supply) and alcohol dependence.</p> <p>R5's Elopement Risk Evaluation dated 5/23/25, indicated R1 was not at risk for elopement and current interventions included a check in and out log.</p> <p>R5's care plan dated 5/23/25, indicated resident was a low elopement risk and was a smoker. Further, R5's care plan indicated he was independent with locomotion in his wheelchair.</p>	F 550	<p>Doors are unlocked between the hours of 8am to 8pm. A list of High risk elopement residents is emailed to department managers each week.</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>All staff were updated via note by timecard of Doors being unlocked from 8am to 8pm. Residents who leave the facility to smoke are aware of signing out of the book to leave the facility and sign back in when coming back. Smoking policy and restraint Free Environment will be reviewed with staff members via electronic communication sent out on 6/19/25 to be completed before thier next shift.</p> <p>The DON/designee will complete random weekly audits for 4 consecutive weeks of interviewing 3 residents who go outside frequently if they have had issues going</p>	

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F 550	<p>Continued From page 3</p> <p>On 5/27/25 at 11:50 a.m., upon entering the facility, the entrance door was observed to be locked and there was a doorbell to ring. Staff appeared and typed in a code to unlock the door.</p> <p>On 5/29/25 at 9:49 a.m., R5 was observed sitting the entry way of the front door in his wheelchair waiting for staff to come unlock the door to come back into the facility. Writer went to grab the health unit coordinator (HUC) to let R5 into the facility.</p> <p>On 5/27/25 at 2:13 p.m., R5 approached writer and appeared to be frustrated. R5 stated the facility was like a "psych ward", its locked and he had to sign in and out like prisoner.</p> <p>On 5/27/25 at 5:12 p.m., director of nursing (DON) stated the front entrance used to be unlocked, however since admitting more "wanderers", we now always lock the front door and require the assistance of staff typing in a code to unlock it, or it will release after 15 seconds as well per fire code. Further, DON stated for cognitively intact residents who were not at risk for eloping, those residents would need to seek out staff assistance to unlock the door.</p> <p>Review of facility policy titled Restraint Free Environment revised 4/21/25, indicated each resident shall attain and maintain his/her highest practical well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. Further, the policy indicated the resident has the right to be treated with respect and dignity, including the right to be</p>	F 550	<p>outside. Interviewee will be documented with questions and date interviewed. Review of audit will be done with IDT the next day of any concerns. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 550	Continued From page 4 free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.	F 550		
F 689 SS=J	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§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 provide assessed supervision needs for 2 of 3 residents (R1, R4) who were at risk for elopement. R1 was able to leave the facility undetected for one hour despite having a wander guard on, which resulted in an immediate jeopardy (IJ).</p> <p>The IJ began on 5/21/25, when R1, while wearing a wander guard bracelet, successfully eloped from the building without the alarm sounding. R1 was allowed out of the locked front entrance by an unknown responsible party (had the pin code to the locked door), crossed a highway, and was found by community members approximately one mile from the facility an hour later, winded but unharmed. The administrator, director of nursing (DON), and nurse consultant were notified of the immediate jeopardy on 5/29/25 at 9:30 a.m. The immediate jeopardy was removed on 5/29/25, but noncompliance remained at the lower score and</p>	F 689	<p>The Policies reviewed were Missing Person/Elopement policy. Carl B's care plan was updated to include interventions to deter elopement such as but not limited to putting a war movie on and talk about farming and Franklin. Carl is currently on a with staff members 24 hours a day. Other 8 resident's identified as high risk of elopement with wandering tendencies will be updated with wandering interventions and identification of exit seeking behaviors. Care planned interventions will be reviewed with IDT and floor staff from all departments on 5-29-25. Kardexs with interventions for staff who missed the meeting will be printed and distributed to the department managers or designee to review prior to the start of their next shifts.</p> <p>All staff will be educated on Missing Persons, Elopements, Interventions for</p>	7/10/25

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

PRINTED: 06/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/30/2025
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F 689	<p>Continued From page 5</p> <p>severity of D, which indicated no actual harm with potential for more than minimal harm which is not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's quarterly Minimal Data Set (MDS) dated 4/23/25, indicated R1 required a walker for mobility and had moderately impaired cognition.</p> <p>R1's care plan, as of 5/27/25, indicated R1 was at risk for elopement related to diagnoses of disorientation, dementia, weakness and as evidenced by comments and attempts to leave the facility, anger outbursts, use of a wander guard, impaired safety awareness, and independence with ambulation. Further, R1's care plan directed staff to: distract resident from wandering by offering pleasant diversions, structured activities of interest, food/fluids, conversation, television books and personalization of resident room. To reduce likelihood of R1 removing wander guard, remove sharp objects from room such as razors, toe nail clippers, forks, knives, and do not allow him to have scissors; resident is on a one-to-one staff until further notice starting on 5/21/25; rights is a high risk elopement; resident was able to leave the property with direct supervision and was not able to leave the facility alone; resident needs direct supervision when outside; and wander guard placed on resident's ankle.</p> <p>Review of facility report number 360612 to the State Agency dated 5/21/25, revealed R1 was looking to acquire a ride to the VA (Veteran Affairs) office to get his benefits. The VA office was on Franklin (a street located in Minneapolis) and the VA office was in the Government Center.</p>	F 689	<p>Wandering and Door Alarms via educational video or in-person meeting before their next shift. Education will be completed in the building with all staff members present on 5-29-25. Quiz is attached to the video for staff members to submit electronically. If in-person attended, attendance sheet signed. Agency Staff will receive an educational video that needs to be completed prior to starting on the floor. The educational video includes Missing Persons, Elopements, Interventions for Wandering and what to do if a Door Alarms will be sent to them via text message or agency staffer representative. Agency staff will be requested to message the DON or designee to notify them of this being completed prior to their shift. Quiz is attached to the video for staff members to submit electronically. List of High Risk of Elopement residents will be attached to competency checklists for agency staff to have on their person for information.</p> <p>The list of high risk elopement residents will be distributed to all departments electronically weekly or with changes for the department managers to distribute to their staff members.</p> <p>Audits completed weekly of high risk elopement list and of agency staff education prior to starting shift weekly x4 weeks, monthly x2 months, and prn. Audits to continue until QAPI team deems significant compliance is achieved.</p>	

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

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F 689	<p>Continued From page 6</p> <p>The facility investigation, revealed R1 had left the facility after 9:30 a.m. and walked to the Government Center. The Government Center notified staff of R1 being there at roughly 10:15 a.m. R1 was in the building. R1 returned to the facility agitated, was assessed for injury, and none noted. Further, R1 eloped as he removed himself from the facility and made his way out of the safe zone to a building in town. Conclusion was R1 left the building at the same time as another resident being brought out for an appointment, despite being on 15 minute checks..</p> <p>R1's Visual Check Sheet every 15-minutes dated 5/21/25, revealed at 9:30 a.m., R1 was observed to be in his bedroom and then the front door. From 9:45 a.m. until 10:45 a.m., there was no record of R1's 15 minute checks being conducted.</p> <p>On 5/27/25 at 3:42 p.m., licensed practical nurse (LPN)-A stated R1 was at risk for elopement, wore a wander guard and often put on his jacket and stated he wanted to go home. LPN-A stated R1 had recently eloped from the facility and walked to the courthouse which was on the highway. LPN-A stated the front entrance was locked and staff were the only ones who know the code to unlock the door to let a visitor or resident out of the building.</p> <p>On 5/27/25 at 4:06 p.m., community member (CM)-A stated one of the custodians at the government center brought R1 into her office and stated he was in the hallway and needed a ride. CM-A stated R1 appeared to be tired and was provided a chair and a glass of water. CM-A stated CM-B called the facility to inform them he was at the Government Center.</p>	F 689		

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

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F 689	<p>Continued From page 7</p> <p>On 5/27/25 at 4:12 p.m., CM-B stated R1 appeared to be out of breath and tired when he got to the Government Center, he had on shoes but did not have a walker with him. CM-B stated she informed the Sheriff's department at 10:11 a.m. on 5/21/25, and asked if they had any missing persons reports, which they did not. CM-B stated she then called the facility and asked if R1 was a resident there and they confirmed he was. CM-B stated she then informed the facility R1 was at the government center to which staff replied, "Oh he is there? We will send someone right there." CM-B stated the facility staff was not aware R1 was not at the facility at the time, which was approximately at 10:30 a.m.</p> <p>On 5/27/25 at 5:12 p.m., DON stated R1 had impaired cognition, was at risk for elopement, and required staff supervision while out of the facility. DON stated she was informed at approximately 10:15 a.m. on 5/21/25, that R1 was not in the building. Further, R1 was on 15-minute safety checks and was last seen by staff at approximately 9:30 a.m., confirming 15-minute checks were not being completed. DON indicated the facility's internal investigation for R1's incident revealed R1 speculated he had to have left with the transportation services as they were in the facility around that time; she also confirmed staff were the only ones who knew the code to open the door, so staff would have had to let the transportation services out of the door and would have seen R1 exit, however no staff would confess.</p> <p>On 5/28/25 at 8:31 a.m., LPN-B stated R1's cognition and safety awareness were impaired.</p>	F 689		

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

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F 689	<p>Continued From page 8</p> <p>R1 required a walker while ambulating to help stability and was determined to be at high risk for eloping and had a wander guard on his ankle. LPN-B stated she was working with R1 on 5/21/25, the day of the incident, and she last observed R1 at 9:00 a.m. in his room not exhibiting any exit seeking behavior. LPN-B stated she was not aware R1 was missing from the facility until the administrator was notified. Further, LPN-B indicated R1 required 15-minute safety checks due to his exit seeking behaviors and elopement history, and she had been completing those safety checks until 9:00 a.m. until NA-D was assigned to R1's care but added, NA-D was not aware R1 required 15-minute checks. In addition, LPN-B stated R1 had reported he waited for staff to unlock the front entrance for the transportation driver and he followed the driver out the front door.</p> <p>On 5/28/25 at 9:17 a.m., NA-D stated she was assigned to R1's care on 5/21/25, and that day was also her first shift working at the facility, as she was a contracted agency staff. NA-D stated she was late for her shift that day and arrived at the facility at approximately 6:30 a.m.. The previous overnight aid was in a rush to get off her shift, so NA-D stated she did not get any verbal report regarding R1 or his safety checks. NA-D also stated she did not receive training prior to the start of her shift and did not have access to any resident's care plans until management arrived at the facility at approximately 9:00 a.m. NA-D confirmed there was a lack communication by facility staff to NA-D regarding which residents were high risk for elopement. Further, NA-D stated she was unsure of the exact time she last saw R1, but did last see him in his room making his bed prior to taking a break. NA-D was not</p>	F 689		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 9</p> <p>aware R1 was out of the facility until staff received a call from the government center.</p> <p>Observation on 5/28/25 at 10:01 a.m., R1 was in his room making his bed with a staff member sitting outside in a chair directly outside his room. R1 stated he had been a "bad boy" and lifted his pant leg to reveal a wander guard on his ankle. Further, R1 stated he had walked right out of the building on 5/21/25 and if he sat and watched long enough staff would open the door and he could take off. R1 stated he walked to the government center, was unsure how far away it was, but denied getting hurt.</p> <p>On 5/28/25 at 11:16 a.m., administrator stated he was made aware of R1's elopement and went to the government center to pick up R1 himself. He indicated the facility's internal investigation determined R1 exited through the front entrance with a visitor or vendor. Administrator stated staff were the only ones who were provided the code, and the only way a visitor or vendor would know the code was if a staff shared it or if they watched a staff input the code. Staff are expected not to share the door codes.</p> <p>On 5/28/25 at 2:17 p.m., NA-E stated she was a contracted agency staff and had worked since 5/21/25. NA-E stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for.</p> <p>On 5/28/25 at 3:33 p.m., LPN-A stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for since the incident with R1 had occurred. LPN-A</p>	F 689		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 10</p> <p>stated she was not here the day of the incident but worked on 5/26/25.</p> <p>On 5/28/25 at 3:40 p.m., DON stated she had sent a text message to staff regarding completing the elopement training but had missed sending the message to LPN-A. DON stated she did not provide a date to the staff to have the education completed by, and would be expected to track and ensure all staff have completed the education, but did not have a process in place to do so at this time.</p> <p>The immediate jeopardy that began on 5/21/25, was removed on 5/29/25, and was verified through observation, interview, and document review when the facility implemented the following interventions:</p> <ul style="list-style-type: none"> -R1's care plan was updated to include interventions to deter elopement such as putting on a war movie and talk about farming and Franklin. -R1 was currently on a one-to-one staff 24 hours a day -Other 8 residents who were identified as high risk of elopement with wandering tendencies would be updated with wandering interventions and identification of exit seeking behaviors. Care planned interventions would be reviewed with interdisciplinary team and floor staff from all departments on 5/29/25. -Kardex's with interventions for staff who missed the meeting would be printed and distributed to the department managers or designee to review prior to the start of their next shifts -All staff will be educated on Missing Persons, Elopements, Interventions for wandering and door alarms by education video or in-person meeting before their next shift. Education would 	F 689		

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

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F 689	<p>Continued From page 11</p> <p>be completed in the building with all staff members on 5/29/25. Quiz was attached to the video for staff members to submit electronically.</p> <p>-Agency staff members received an educational video that needed to be completed prior to starting the floor. The educational video included Missing Persons, Elopements, Interventions and what to do if the door alarms. Agency staff would notify DON of this being completed prior to their shift.</p> <p>-List of High-Risk Elopement residents would be attached to competency checklists for agency staff to have on their person for information.</p> <p>-A list of high-risk elopement resident was distributed to all departments electronically weekly and with changes for the managers to distribute to their staff members.</p> <p>R4's quarterly MDS dated 4/18/25, indicated R4 had diagnoses that included dementia, and cognitive communication deficit. R4 had no cognitive impairments and did not exhibit wandering behaviors.</p> <p>R4's care plan dated as of 5/27/25, indicated R4 was an elopement risk and R4 had a history of attempting to leave the facility. Further, R4's care plan identified R4 as a high risk for elopement, required direct supervision while outside and directed staff to ensure sign in/out log when family was taking resident out of building. R4 had a wander guard on his ankle.</p> <p>Observation on 5/27/25 at 1:42 p.m., an unidentified male resident approached dietary cook (DC)- A and asked DC-A to assist him with unlocking the front door to go outside. DC-A agreed and using a code on the front door, let the resident out of the building along with R4, who</p>	F 689		

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F 689	<p>Continued From page 12</p> <p>followed behind with his walker and was wearing a jacket. The alarm on the door sounded. DC-A closed the door and walked away. DON came out of office, looked outside through the glass door and headed directly outside where she was observed talking to R4 and visitors. Upon her return, DC-A turned around and stated "what, was he not supposed to be outside?" and continued to walk down the hallway. At 1:45 p.m., DON approached DC-A and stated R4 had family outside but otherwise he was not allowed outside unsupervised. DC-A responded with "he was suited up and ready to go, I didn't know".</p> <p>On 5/27/25 at 1:47 p.m., DON stated R4 was assessed to be an elopement risk and required supervision while outside the facility. Today R4 happened to have family sitting outside so was not put at risk when he was let out of the building by DC-A. Further, DON stated elopement risk and interventions were identified in each resident's care plan, however dietary or housekeeping staff do not have access to resident care plans and would need to be notified verbally by their supervisors of residents who were at risk for elopement and required supervision.</p> <p>Review of facility policy titled Elopement and Wandering Residents, undated, indicated the facility ensure that residents who exhibit wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements, but alarms were not a replacement for necessary supervision. Staff were to be</p>	F 689		

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F 689	Continued From page 13 vigilant in responding to alarms in a timely manner. Further, 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.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		6/26/25

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 726	<p>Continued From page 14 §483.35(d) Proficiency of nurse aides.</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure contracted resident care staff were competently trained on facility resident procedures, as well as provided access to electronic medical records (EMR) to implement person-centered resident care needs, interventions related to resident care to ensure safety and reduce the risk of complication (i.e. elopement). This had the potential to affect all 46 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On 5/28/25 at 9:17 a.m., nursing assistant (NA)-D stated her first shift working at the facility was on 5/21/25. NA-D stated she received no training for the facility prior to the start of her shift and did not have access to any of the resident's care plans until management arrived at the facility at approximately 9:00 a.m.</p> <p>On 5/28/25 at 3:40 p.m. director of nursing (DON) stated contracted agency staff were expected to complete the packet that was printed and placed at the front desk before they would start working on the floor. Further, DON stated they would be assigned a staff member to assist them with completing the packet and would be given access to the EMR at the beginning of their shift as well. In addition, DON confirmed NA-D did not</p>	F 726	<ol style="list-style-type: none"> 1. Immediate action(s) taken for the resident(s) found to have been affected include A list of high risk elopement residents was created and printed for all new temporary agency for there first shift. A list of high risk elopement residents is emailed out weekly for all departments. The list is printed for the nursing department to review with changes. 2. 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. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:An elopement list was placed at the nurses station for review as needed for staff members. An elopement risk list and Elopement Video were produced. Video and list are to be viewed prior to the start of there shift. Contact with Pool Agency Representative was requested to assist to getting the video out to staff members. A designee to the nursing schedule has been assigned to assure Competency Packet, Video and high risk elopement list are given to Agency Staff prior to starting first shift. A designee has been assigned to assure EMR access is 	

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

PRINTED: 06/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/30/2025
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277		
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F 726	Continued From page 15 complete the required training prior to working her shift on 5/21/25. Review of facility policy titled Contract Employees Emergency Preparedness Training, not dated, indicated the facility was to share appropriate information from the facility's emergency plan with contracted employee, however policy did not address receiving access to EMR or education related to other facility policies such as elopements.	F 726	created prior to the start of the Agency Staff shift. Competency packet is to be completed prior to outgoing staff members leaving the building. Agency Staff will be requested to come in a half hour early to assure packet is completed. Competency checklists will be reviewed by DON or designee to assure competency packets are filled out. Education will be given electronically to staff to complete prior to their next shift on 6/20/25. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete weekly audits for 4 consecutive weeks to assure the high risk resident list is emailed out weekly, new agency staff members have received a competency packet, the packet is filled out and completed and EMR access is accessible. Audits will continue after that monthly for 2 months and then as needed there after. Immediate issues will be addressed with IDT. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2025
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NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 5/27/25 through 5/30/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/20/25
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2025
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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed:</p> <p>H52905389C (MN00113300) with a licensing order issued at 0830.</p> <p>H52905687C (MN00113366).</p> <p>In addition, as a result of the investigation licensing orders at 0300 and 1880 were issued.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to</p>	2 000		
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2 000	<p>Continued From page 2</p> <p>you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>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</p>	2 000		
2 300	<p>MN Rule 4658.0105 Competency</p> <p>A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure contracted resident care staff were competently trained on facility resident procedures, as well as provided access to electronic medical records (EMR) to implement person-centered resident care needs, interventions related to resident care to ensure safety and reduce the risk of complication (i.e.</p>	2 300	Corrected	5/30/25

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2 300	<p>Continued From page 3</p> <p>elopement). This had the potential to affect all 46 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On 5/28/25 at 9:17 a.m., nursing assistant (NA)-D stated her first shift working at the facility was on 5/21/25. NA-D stated she received no training for the facility prior to the start of her shift and did not have access to any of the resident's care plans until management arrived at the facility at approximately 9:00 a.m.</p> <p>On 5/28/25 at 3:40 p.m. director of nursing (DON) stated contracted agency staff were expected to complete the packet that was printed and placed at the front desk before they would start working on the floor. Further, DON stated they would be assigned a staff member to assist them with completing the packet and would be given access to the EMR at the beginning of their shift as well. In addition, DON confirmed NA-D did not complete the required training prior to working her shift on 5/21/25.</p> <p>Review of facility policy titled Contract Employees Emergency Preparedness Training, not dated, indicated the facility was to share appropriate information from the facility's emergency plan with contracted employee, however policy did not address receiving access to EMR or education related to other facility policies such as elopements.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to contract staff competencies and implement a training program and/or perform competencies on tasks performed. The</p>	2 300		
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2 300	Continued From page 4 administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
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 provide assessed supervision needs for 2 of 3 residents (R1, R4) who were at risk for elopement. R1 was able to	2 830	Corrected.	5/30/25

Minnesota Department of Health

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2 830	<p>Continued From page 5</p> <p>leave the facility undetected for one hour despite having a wander guard on.</p> <p>Findings include:</p> <p>R1's quarterly Minimal Data Set (MDS) dated 4/23/25, indicated R1 required a walker for mobility and had moderately impaired cognition.</p> <p>R1's care plan, as of 5/27/25, indicated R1 was at risk for elopement related to diagnoses of disorientation, dementia, weakness and as evidenced by comments and attempts to leave the facility, anger outbursts, use of a wander guard, impaired safety awareness, and independence with ambulation. Further, R1's care plan directed staff to: distract resident from wandering by offering pleasant diversions, structured activities of interest, food/fluids, conversation, television books and personalization of resident room. To reduce likelihood of R1 removing wander guard, remove sharp objects from room such as razors, toe nail clippers, forks, knives, and do not allow him to have scissors; resident is on a one-to-one staff until further notice starting on 5/21/25; rights is a high risk elopement; resident was able to leave the property with direct supervision and was not able to leave the facility alone; resident needs direct supervision when outside; and wander guard placed on resident's ankle.</p> <p>Review of facility report number 360612 to the State Agency dated 5/21/25, revealed R1 was looking to acquire a ride to the VA (Veteran Affairs) office to get his benefits. The VA office was on Franklin (a street located in Minneapolis) and the VA office was in the Government Center. The facility investigation, revealed R1 had left the facility after 9:30 a.m. and walked to the</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>Government Center. The Government Center notified staff of R1 being there at roughly 10:15 a.m. R1 was in the building. R1 returned to the facility agitated, was assessed for injury, and none noted. Further, R1 eloped as he removed himself from the facility and made his way out of the safe zone to a building in town. Conclusion was R1 left the building at the same time as another resident being brought out for an appointment, despite being on 15 minute checks..</p> <p>R1's Visual Check Sheet every 15-minutes dated 5/21/25, revealed at 9:30 a.m., R1 was observed to be in his bedroom and then the front door. From 9:45 a.m. until 10:45 a.m., there was no record of R1's 15 minute checks being conducted.</p> <p>On 5/27/25 at 3:42 p.m., licensed practical nurse (LPN)-A stated R1 was at risk for elopement, wore a wander guard and often put on his jacket and stated he wanted to go home. LPN-A stated R1 had recently eloped from the facility and walked to the courthouse which was on the highway. LPN-A stated the front entrance was locked and staff were the only ones who know the code to unlock the door to let a visitor or resident out of the building.</p> <p>On 5/27/25 at 4:06 p.m., community member (CM)-A stated one of the custodians at the government center brought R1 into her office and stated he was in the hallway and needed a ride. CM-A stated R1 appeared to be tired and was provided a chair and a glass of water. CM-A stated CM-B called the facility to inform them he was at the Government Center.</p> <p>On 5/27/25 at 4:12 p.m., CM-B stated R1 appeared to be out of breath and tired when he</p>	2 830		
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2 830	<p>Continued From page 7</p> <p>got to the Government Center, he had on shoes but did not have a walker with him. CM-B stated she informed the Sheriff's department at 10:11 a.m. on 5/21/25, and asked if they had any missing persons reports, which they did not. CM-B stated she then called the facility and asked if R1 was a resident there and they confirmed he was. CM-B stated she then informed the facility R1 was at the government center to which staff replied, "Oh he is there? We will send someone right there." CM-B stated the facility staff was not aware R1 was not at the facility at the time, which was approximately at 10:30 a.m.</p> <p>On 5/27/25 at 5:12 p.m., DON stated R1 had impaired cognition, was at risk for elopement, and required staff supervision while out of the facility. DON stated she was informed at approximately 10:15 a.m. on 5/21/25, that R1 was not in the building. Further, R1 was on 15-minute safety checks and was last seen by staff at approximately 9:30 a.m., confirming 15-minute checks were not being completed. DON indicated the facility's internal investigation for R1's incident revealed R1 speculated he had to have left with the transportation services as they were in the facility around that time; she also confirmed staff were the only ones who knew the code to open the door, so staff would have had to let the transportation services out of the door and would have seen R1 exit, however no staff would confess.</p> <p>On 5/28/25 at 8:31 a.m., LPN-B stated R1's cognition and safety awareness were impaired. R1 required a walker while ambulating to help stability and was determined to be at high risk for eloping and had a wander guard on his ankle. LPN-B stated she was working with R1 on</p>	2 830		
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2 830	<p>Continued From page 8</p> <p>5/21/25, the day of the incident, and she last observed R1 at 9:00 a.m. in his room not exhibiting any exit seeking behavior. LPN-B stated she was not aware R1 was missing from the facility until the administrator was notified. Further, LPN-B indicated R1 required 15-minute safety checks due to his exit seeking behaviors and elopement history, and she had been completing those safety checks until 9:00 a.m. until NA-D was assigned to R1's care but added, NA-D was not aware R1 required 15-minute checks. In addition, LPN-B stated R1 had reported he waited for staff to unlock the front entrance for the transportation driver and he followed the driver out the front door.</p> <p>On 5/28/25 at 9:17 a.m., NA-D stated she was assigned to R1's care on 5/21/25, and that day was also her first shift working at the facility, as she was a contracted agency staff. NA-D stated she was late for her shift that day and arrived at the facility at approximately 6:30 a.m.. The previous overnight aid was in a rush to get off her shift, so NA-D stated she did not get any verbal report regarding R1 or his safety checks. NA-D also stated she did not receive training prior to the start of her shift and did not have access to any resident's care plans until management arrived at the facility at approximately 9:00 a.m. NA-D confirmed there was a lack communication by facility staff to NA-D regarding which residents were high risk for elopement. Further, NA-D stated she was unsure of the exact time she last saw R1, but did last see him in his room making his bed prior to taking a break. NA-D was not aware R1 was out of the facility until staff received a call from the government center.</p> <p>Observation on 5/28/25 at 10:01 a.m., R1 was in his room making his bed with a staff member</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 9</p> <p>sitting outside in a chair directly outside his room. R1 stated he had been a "bad boy" and lifted his pant leg to reveal a wander guard on his ankle. Further, R1 stated he had walked right out of the building on 5/21/25 and if he sat and watched long enough staff would open the door and he could take off. R1 stated he walked to the government center, was unsure how far away it was, but denied getting hurt.</p> <p>On 5/28/25 at 11:16 a.m., administrator stated he was made aware of R1's elopement and went to the government center to pick up R1 himself. He indicated the facility's internal investigation determined R1 exited through the front entrance with a visitor or vendor. Administrator stated staff were the only ones who were provided the code, and the only way a visitor or vendor would know the code was if a staff shared it or if they watched a staff input the code. Staff are expected not to share the door codes.</p> <p>On 5/28/25 at 2:17 p.m., NA-E stated she was a contracted agency staff and had worked since 5/21/25. NA-E stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for.</p> <p>On 5/28/25 at 3:33 p.m., LPN-A stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for since the incident with R1 had occurred. LPN-A stated she was not here the day of the incident but worked on 5/26/25.</p> <p>On 5/28/25 at 3:40 p.m., DON stated she had sent a text message to staff regarding completing the elopement training but had missed sending</p>	2 830		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2025
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NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277
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2 830	<p>Continued From page 10</p> <p>the message to LPN-A. DON stated she did not provide a date to the staff to have the education completed by, and would be expected to track and ensure all staff have completed the education, but did not have a process in place to do so at this time.</p> <p>R4's quarterly MDS dated 4/18/25, indicated R4 had diagnoses that included dementia, and cognitive communication deficit. R4 had no cognitive impairments and did not exhibit wandering behaviors.</p> <p>R4's care plan dated as of 5/27/25, indicated R4 was an elopement risk and R4 had a history of attempting to leave the facility. Further, R4's care plan identified R4 as a high risk for elopement, required direct supervision while outside and directed staff to ensure sign in/out log when family was taking resident out of building. R4 had a wander guard on his ankle.</p> <p>Observation on 5/27/25 at 1:42 p.m., an unidentified male resident approached dietary cook (DC)- A and asked DC-A to assist him with unlocking the front door to go outside. DC-A agreed and using a code on the front door, let the resident out of the building along with R4, who followed behind with his walker and was wearing a jacket. The alarm on the door sounded. DC-A closed the door and walked away. DON came out of office, looked outside through the glass door and headed directly outside where she was observed talking to R4 and visitors. Upon her return, DC-A turned around and stated "what, was he not supposed to be outside?" and continued to walk down the hallway. At 1:45 p.m., DON approached DC-A and stated R4 had family outside but otherwise he was not allowed outside unsupervised. DC-A responded with "he was</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 11</p> <p>suited up and ready to go, I didn't know".</p> <p>On 5/27/25 at 1:47 p.m., DON stated R4 was assessed to be an elopement risk and required supervision while outside the facility. Today R4 happened to have family sitting outside so was not put at risk when he was let out of the building by DC-A. Further, DON stated elopement risk and interventions were identified in each resident's care plan, however dietary or housekeeping staff do not have access to resident care plans and would need to be notified verbally by their supervisors of residents who were at risk for elopement and required supervision.</p> <p>Review of facility policy titled Elopement and Wandering Residents, undated, indicated the facility ensure that residents who exhibit wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements, but alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. Further, 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.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and</p>	2 830		

Minnesota Department of Health

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2 830	Continued From page 12 implement measures to ensure appropriate supervision for elopement prevention. The director of nursing or designee, should conduct measurable audits of elopement interventions to ensure staff are aware of interventions, implementing interventions appropriately, and identify if current interventions are appropriate and effective to prevent elopements. 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		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every	21880		5/30/25

Minnesota Department of Health

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21880	<p>Continued From page 13</p> <p>facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a system to ensure residents who were cognitively intact, and not an elopement risk could freely enter and exit the facility for 1 of 1 residents (R5) reviewed for resident rights.</p> <p>Findings include:</p> <p>R5' Face sheet dated 5/27/25, indicated R5 was admitted to the facility on 5/23/25 and his diagnoses included osteonecrosis (death of bone tissue due to a lack of blood supply) and alcohol dependence.</p>	21880	Correct	
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21880	<p>Continued From page 14</p> <p>R5's Elopement Risk Evaluation dated 5/23/25, indicated R1 was not at risk for elopement and current interventions included a check in and out log.</p> <p>R5's care plan dated 5/23/25, indicated resident was a low elopement risk and was a smoker. Further, R5's care plan indicated he was independent with locomotion in his wheelchair.</p> <p>On 5/27/25 at 11:50 a.m., upon entering the facility, the entrance door was observed to be locked and there was a doorbell to ring. Staff appeared and typed in a code to unlock the door.</p> <p>On 5/29/25 at 9:49 a.m., R5 was observed sitting the entry way of the front door in his wheelchair waiting for staff to come unlock the door to come back into the facility. Writer went to grab the health unit coordinator (HUC) to let R5 into the facility.</p> <p>On 5/27/25 at 2:13 p.m., R5 approached writer and appeared to be frustrated. R5 stated the facility was like a "psych ward", its locked and he had to sign in and out like prisoner.</p> <p>On 5/27/25 at 5:12 p.m., director of nursing (DON) stated the front entrance used to be unlocked, however since admitting more "wanderers", we now always lock the front door and require the assistance of staff typing in a code to unlock it, or it will release after 15 seconds as well per fire code. Further, DON stated for cognitively intact residents who were not at risk for eloping, those residents would need to seek out staff assistance to unlock the door.</p> <p>Review of facility policy titled Restraint Free Environment revised 4/21/25, indicated each</p>	21880		
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Minnesota Department of Health

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21880	<p>Continued From page 15</p> <p>resident shall attain and maintain his/her highest practical well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. Further, the policy indicated the resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.</p> <p>SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident rights and restrictions and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident rights are being honored, reviewed then audit to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21880		