Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2025

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

RE: CCN: 245290
Cycle Start Date: February 14, 2025

Dear Administrator:

On February 28, 2025, we notified you a remedy was imposed. On March 19, 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 March 14, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 15, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 28, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 14, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 25, 2025

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

Re: Reinspection Results
Event ID: 77X612

Dear Administrator:

On March 19, 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 February 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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
February 28, 2025

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

RE: CCN: 245290
Cycle Start Date: February 14, 2025

Dear Administrator:

On February 14, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 March 15, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 15, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 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.

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

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.

If you have not achieved substantial compliance by March 15, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Olivia Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Steven.Delich@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 Steven.Delich@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)

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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 77X611

Dear Administrator:

The above facility was surveyed on February 13, 2025 through February 14, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 02/14/2025

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 On 2/13/25 through 2/14/25, 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. The following complaints were reviewed H52907505C (MN00110642) and H52907247C (MN00110563), with deficiencies cited at F684, F727, and F940. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		3/12/25

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

Electronically Signed | 03/10/2025

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.

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 684	Continued From page 1 by: Based on interview and document review, the facility failed to complete an assessment including, vital signs and general condition, when a change in condition was reported to a nurse for 1 of 3 (R1) residents reviewed for quality of care. This resulted in harm for R1 who continued to decline and later that day required emergency medical care and passed away. Findings include: R1's admission Minimum Data Set (MDS), dated 1/22/25, indicated R1 had diagnoses of multiple sclerosis, sepsis (a serious infection), and acute ischemia of the intestine (when the blood flow to the intestine is suddenly cut off). R1's MDS indicated she required substantial assistance with all activities of daily living (ADLs) and was cognitively intact. R1's care plan, dated 1/22/25, indicated R1 was dependent on staff assistance for bed mobility, dressing and personal hygiene. R1's care plan indicated she was dependent on the assistance of staff to pivot transfer to/from the bed to the wheelchair or commode. A Physicians Order for Life Sustaining Treatment (POLST), dated 1/21/25, indicated R1 wanted cardiopulmonary resuscitation (CPR) attempted, if she had no pulse and was not breathing. A progress note on 2/8/25 at 4:15 p.m., indicated R1 was ill that morning with nausea and vomiting and "did not keep her pills down". R1 continued to have vomiting and diarrhea throughout the day. R1 refused all meals and told nursing assistant (NA)-A she did not feel well. When NA-A provided	F 684	F684: Staff education provided to RN-A, NA-B and NA-C on providing notification to charge nurse and charge nurse to provide notification to Physician when observing significant change of resident medical condition and to complete an assessment and vital signs. Education also provided to staff reminding them to continue CPR until EMS arrives on scene to take over the medical condition, as outlined by the American Heart Association guidelines regarding CPR. Education to staff provided on Facility's Notification of Changes Policy. Education also provided on location of AED devices within the facility by following the AED signage placards, which show the direct locations of the AED's. All residents in the facility have the potential to be affected by the deficient practice. Staff education was reviewed and discussed with facility Medical Director during QAPI on February 24, 2025. Staff education was reviewed and discussed on Facility policy on Notification of Changes reviewed with staff during All-Staff meeting held on February 25, 2025 and again on March 11, 2025. Monitoring the correction actions will be accomplished through audits conducted 5 times weekly for 8 weeks to monitor compliance on resident significant	

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F 684	Continued From page 2 cares around 1:00 p.m., R1 was alert and talking. NA-B observed R1 to have a nosebleed around 3:30 p.m. and became unresponsive. 911 was called. At 3:44 p.m. R1 became blue and had no pulse. Registered nurse (RN)-A started CPR. RN-A began CPR and sent staff to get the AED (automated external defibrillator, device used to analyze heart rhythm and deliver electric shock to restore normal rhythm during cardiac arrest). AED was applied and shock was not advised. CPR resumed for three cycles of CPR and analyzing via the AED. R1 still didn't have a pulse and was bleeding from the nose and mouth. CPR ceased when ambulance arrived. Emergency medical services (EMS) staff hooked resident up to their monitor. R1 was asystole (a cardiac arrest rhythm where the heart's electrical and mechanical activity stops completely). RN-A indicated she notified the director of nursing (DON) of the R1's death. R1's progress notes lacked notification to the provider of R1's deterioration in condition prior to her death. On 2/13/25 at 1:33 p.m., NA-C stated he was working on 2/8/25. NA-C stated he assisted RN-A and NA-B in CPR efforts for R1. NA-C stated he could not remember how long they performed CPR. NA-C stated EMS staff asked RN-A why they stopped CPR and RN-A replied, "she died." On 2/13/25 at 2:04 p.m., RN-A stated she worked from 6:00 a.m. to 6:30 p.m. on 2/8/25. R1 had nausea, vomiting, and diarrhea all day. RN-A stated she became aware of R1's change in condition around 7:45 a.m. when R1 vomited after taking her morning medications. RN-A stated R1 refused breakfast and lunch. She did	F 684	changes in medical condition being reported to Physician with assessment and vital signs. Results will be reviewed at morning IDT, (Inter-Disciplinary Meetings), and at monthly QAPI meeting held in March and April, 2025, to ensure continued compliance and any root-cause analysis related to any future education and procedural needs. Date of correction: March 11, 2025	

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F 684	Continued From page 3 not contact R1's provider because it was a Saturday. She did not do a physical assessment to further investigate R1's change in condition and did not take her vital signs (blood pressure, temperature, pulse, and respiratory rate) even though R1 was ill. RN-A stated there was a virus going around the building, where other residents had similar symptoms of nausea, vomiting and diarrhea. RN-A stated R1 had a nosebleed and became unresponsive around 3:00 p.m. RN-A stated she called 911 and then started CPR. RN-A stated she could not recall a timeline. The staff completed two-to-three cycles of CPR with AED in place. RN-A stated, "When they (EMS) got there, we kind of stopped." RN-A stated CPR should not have been stopped prior to EMS arrival. On 2/13/25 at 3:09 p.m., the DON stated she was informed CPR was performed on R1 on 2/8/25. The DON stated RN-A told her EMS staff took over when they arrived. The DON stated she would not expect CPR to cease prior to EMS taking over. On 2/13/25 at 3:45 p.m., EMS-A stated a NA met the EMS staff at the door, upon their arrival, stating CPR was in progress. EMS-A stated when they entered R1's room, nobody was doing CPR and RN-A was removing her gloves and stated, "I am done doing CPR. She is gone." EMS-A stated the AED was out and the pads were on R1's chest. EMS-A stated she would not have expected CPR to cease prior to their arrival. On 2/13/25 at 4:18 p.m., EMS-B stated as she was entering the facility with equipment, EMS-A met her in the hall to inform her staff discontinued CPR. EMS-B stated she was surprised CPR was	F 684		

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F 684	Continued From page 4 discontinued as it is usually continued until EMS takes over. EMS-B stated RN-A told her 5 cycles of CPR were completed, which would be approximately ten minutes. EMS-B stated they applied the pads of their equipment to determine R1 was "asystole and pupils were fixed and dilated." On 2/13/25 at 5:35 p.m. nursing assistant (NA)-A stated, on 2/8/25, he informed RN-A around 7:00 a.m., R1 was not feeling well. NA-A informed RN-A, R1 had vomiting and diarrhea. R1 had several more episodes of vomiting and diarrhea. R1 refused her breakfast and her lunch. NA-A stated he informed RN-A of these concerns throughout his shift (6:00 a.m. - 2:30 p.m.). NA-A stated he observed RN-A enter the room to provide R1 her medications around 7:45 a.m. NA-A was not advised by RN-A to obtain vital signs for R1. On 2/14/25 at 10:12 a.m., NA-B stated she checked on R1 around 3:30 p.m. on 2/8/25. NA-B observed blood coming from R1's nose. RN-A came into the room and said she was going to call 911, without completing vital signs or an assessment. NA-B stated she was preparing to wash R1 to get her ready to go to the hospital when she observed R1 was no longer breathing. While NA-B and RN-A were both in R1's room, NA-B informed RN-A R1 was not breathing. NA-B stated the head of R1's bed was lowered, and she went to gather the crash cart and AED. When she returned to the room, RN-A was performing CPR on R1. NA-B stated she applied the AED pads and the AED said not to shock R1. They performed two cycles of analyzing with the AED. RN-A was using the ambu-bag (a device used to deliver breaths to a person) to deliver breaths	F 684		

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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 684	Continued From page 5 while NA-C did compressions. NA-B stated she exited R1's room when she saw the ambulance in the parking lot and met the EMS staff at the door. NA-B informed EMS staff CPR was in progress. When NA-B and EMS staff returned to R1's room, the staff were no longer performing CPR. NA-B stated she did not know why CPR was stopped. RN-A just stated they stopped. NA-B stated she heard EMS staff asking RN-A why they stopped doing CPR. NA-B stated R1 was on a hospital bed, with a mattress, while CPR was performed. NA-B stated there was a CPR board on the crash cart, but it was never placed under R1. She stated "nobody thought to grab it." On 2/14/25 at 10:53 a.m., the director DON stated RN-A should have updated the provider with R1's change in condition on 2/8/25 after she vomited her morning medications. The DON stated she expected vital signs and assessment should have been completed "more than once" throughout the day. On 2/14/25 at 2:39 p.m. the medical director (MD) stated he would have expected RN-A to have completed an assessment and vital signs when she started to show signs of illness. Based on the findings, he would expect RN-A would have had communication with the provider to evaluate R1's condition. On 2/14/25 at 2:50 p.m., the nurse practitioner (NP) stated he saw R1 on 2/6/25 and she did not have any of the symptoms noted in the progress note dated 2/8/25. The NP stated he would have expected RN-A to complete and assessment with vital signs. He stated RN-A did not inform him of R1's change in condition on 2/8/25. The NP stated there is always a provider on-call to	F 684		

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F 684	Continued From page 6 address the needs of the residents. A facility document, Notification of Changes, dated 8/24, directed the facility promptly informs the resident, consults the physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. 2) Significant change in the resident's physical, mental, or psychosocial condition such as a deterioration in health, mental, or psychosocial status. This may include clinical complications. 3) Circumstances that require need to alter treatment. This may include acute condition. A facility document, Cardiopulmonary Resuscitation, dated 2023, directed the facility will follow current American Heart Association (AHA) guidelines regarding CPR. The AHA Adult Basic Life Support Algorithm for Healthcare Providers, dated 2020, directed to start CPR if no breathing and no pulse felt, use AED as it is available, check for shockable rhythm, resume CPR immediately for 2 minutes (until prompted by AED), and continue until ALS (advanced Life Support) providers take over or victim starts to move.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under	F 727		2/18/25

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F 727	Continued From page 7 paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to employ a full-time director of nursing (DON). This had the opportunity to affect all 36 residents. Findings include: During observations on 2/13/25 and 2/14/25, the DON was not present in the facility. On 2/13/25 at 3:09 p.m., the DON stated she came to the facility two to three times per week. On 2/14/25 at 10:53 a.m., the DON stated her responsibility for the facility was to manage the staff and "make sure everybody is complying with what they are supposed to." The DON stated the facility "struggled with management and leadership." The DON stated, "I am not in the building everyday. I live a long way away." On 2/14/25 at 2:39 p.m., the DON stated she was in the facility one to two times per week, but did not track how frequently she was in the building. The DON stated she was in the facility twice during the week of 2/10/25 through 2/14/25. On 2/14/25 at 2:56 p.m., the administrator stated he was aware the facility was supposed to have a full-time DON.	F 727	F727: The facility has had a full-time interim Director of Nursing hired for the facility after the former Director of Nursing had resigned. A permanent, full-time Director of Nursing has been employed at the facility, with start date of Tuesday, February 18, 2025. Notification of the name and license # of the new, permanent Director of Nursing was sent to the State of Minnesota on March 6, 2025. The new, permanent Director of Nursing began her first day of employment in the facility on February 18th, 2025 and took over the full-time duties of full-time, interim Director of Nursing on this date. An employment offer was accepted by the new Director of Nursing in January, 2025 with start date that had been established for February 18, 2025. If a full-time Director of Nursing were not hired for the facility, all residents would have the potential to be affected. The new, permanent Director of Nursing participated in the February 24th, 2025 QAPI meeting and participated with the facility Medical Director in attendance.	

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F 727	Continued From page 8	F 727		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide training to individuals providing services under a contractual agreement, consistent with their expected roles. This had the opportunity to affect all 36 residents of the facility. Findings include: On 2/13/25 at 2:04 p.m. registered nurse (RN)-A, who worked at the facility through an agency, stated she was not provided orientation to the facility or the facility policies and procedures. She stated she was "thrown in" on her first shift. RN-A stated she was the only nurse in the building on the shifts she worked. On 2/13/25 at 2:24 p.m. RN-B, who worked at the facility through an agency, stated the facility did not provide orientation. RN-B stated he was frequently the only nurse in the building, when he	F 940	Date of correction: February 18, 2025. F940: Facility orientation policy has been reviewed and checklist developed for newly hired staff that includes both contracted and permanent employees. Documentation of orientation completion shall be signed by the employee and the trainer, and dated, and kept in the employee's personnel file to provide evidence that orientation was provided. RN-A, RN-B and RN-C were provided employee orientation on February 25, 2025, for facility layout and facility policy and procedures. All residents have the potential to be impacted by the deficient practice of not possessing records that agency and new hired employees received an orientation to the facility and review of the facility's	3/14/25

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F 940	Continued From page 9 worked. On 2/13/25 at 2:43 p.m., RN-C who worked at the facility through an agency, stated the facility did not provide orientation. RN-C stated sometimes she is the only nurse in the building. On 2/13/25 at 3:09 p.m., the director of nursing (DON) stated the agency nurses should get orientation from the nurse who is reporting off to them. When asked if the facility provided agency staff with training on facility policies, she stated, "I'm sure they do, but I'm not 100% sure." On 2/14/25 at 10:53 a.m., the DON stated she was not sure if there was an exact process for providing orientation to the agency nurses. On 2/14/25 at 1:11 p.m., the administrator stated agency staff should be provided orientation, a review of policies and tour on their first shift at the facility. The administrator stated he was not able to locate evidence of orientation for the agency nurses. A facility document, Orientation policy, dated 2023, directed it is the policy of this facility to develop, implement, and maintain an effective orientation process for all staff, individuals providing services under contractual agreement, and volunteers consistent with their roles. General orientation must be completed prior to the employee's formal contact with facility residents. All documentation to support completion of the orientation process shall be maintained in the employees personnel file. Evidence of facility orientation for agency staff	F 940	policies and procedures. Employees, contracted and permanent, prior to working independently on direct cares, will have documentation that employee orientation was provided to them. Records of completed orientation, signed by the employee, will be kept in employee personnel files, to provide evidence that orientation was provided. These documentations will be kept secured to help prevent risk of this documentation being removed from the facility. The facility will monitor the corrective action by conducting weekly audits for 8 weeks, to monitor and verify that all new hires and existing agency staff completed an employee orientation. New hires will be reviewed for completing orientation at morning Inter-Disciplinary, (IDT), meetings and audits will be will reviewed at March and April QAPI meetings with facility Medical Director. Date of correction: March 14, 2025.	

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F 940	Continued From page 10 was requested, but not received.	F 940		

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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 2/13/25 through 2/14/25, 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	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52907505C (MN00110642) and H52907247C (MN00110563) with licensing orders issued at 4658.0085 Subpart B, 4658.0500 Subpart 2, and 4658.0115. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 310	MN Rule 4658.0115 Work Period A nursing home must not schedule a person to duty for more than one consecutive work period except in a documented emergency. For purposes of this chapter, a documented emergency means situations where replacement staff are not able to report to duty for the next shift due to adverse weather conditions, natural disasters, illness, strike, or other documented situations where normally scheduled staff are no longer available. For purposes of this chapter, a normal work period must not exceed 12 hours. For purposes of this chapter, documentation of an emergency means a written record of the emergency. Documentation on the work schedule is one method of providing written record of the emergency. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility employed nurses to work extended shifts on two occasions, this had the opportunity to affect all 36 residents of the facility. Findings include:	2 310	Corrected	2/21/25

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2 310	Continued From page 3 On 2/13/25 at 2:24 p.m., registered nurse (RN)-B indicated he worked a shift over 24 hours straight on 1/25/25. RN-B indicated he was the only nurse on duty. RN-B stated, "it's not safe for us". RN-B stated the director of nursing (DON) was aware of him working over 24 hours. On 2/13/25 at 3:09 p.m., the DON stated she believed nurses were limited to working 16 hours, but stated they had nurses work extended shifts on two occasions. The DON stated the assistant director of nursing (ADON) was not instructed to work over 24 hours straight on 1/10/25. She stated the ADON could have left for six hours, but decided to stay. The DON stated RN-B also worked a 24 hour shift on 1/25/25. On 2/14/25 at 1:11 p.m., the administrator stated he was aware the ADON worked an extended shift the month prior. The administrator stated there was a call in on 1/26/25 and RN-B worked over 24 hours. He stated RN-B was "ok with it". The administrator stated the DON was aware RN-B was going to work 24 hours and did not come in to the facility because she was unavailable. A facility document, time card, dated 1/10/25 to 1/11/25, indicated the ADON started work at 6:40 a.m. on 1/10/25 and ended work at 8:50 a.m. on 1/11/25. The time card lacked any additional time stamps. A facility document, time card, dated 1/25/25 to 1/26/25, indicated RN-B started work at 8:21 p.m. on 1/25/25 and ended work at 8:06 p.m. on 1/26/25. The time card lacked any additional time stamps.	2 310		

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2 310	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The facility could review staffing opportunities and create a plan The facility could implement a policy to limit the number of hours worked, except in emergency situations. The facility could document emergency situations where extended shifts are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 310		
2 720	MN Rule 4658.0500 Subp. 2 Director of Nursing Services; full time Subp. 2. Requirement of full-time employment. A director of nursing services must be employed full time, no less than 35 hours per week, and be assigned full time to the nursing services of the nursing home. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to employ a full-time director of nursing (DON). This had the opportunity to affect all 36 residents. Findings include: During observations on 2/13/25 and 2/14/25, the DON was not present in the facility. On 2/13/25 at 3:09 p.m., the DON stated she came to the facility two to three times per week. On 2/14/25 at 10:53 a.m., the DON stated her responsibility for the facility was to manage the	2 720	Corrected.	2/18/25

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2 720	Continued From page 5 staff and "make sure everybody is complying with what they are supposed to." The DON stated the facility "struggled with management and leadership." The DON stated, "I am not in the building everyday. I live a long way away." On 2/14/25 at 2:39 p.m., the DON stated she was in the facility one to two times per week, but did not track how frequently she was in the building. The DON stated she was in the facility twice during the week of 2/10/25 through 2/14/25. On 2/14/25 at 2:56 p.m., the administrator stated he was aware the facility was supposed to have a full-time DON. SUGGESTED METHOD OF CORRECTION: The facility could hire a full-time director of nursing (DON) to be assigned no less than 35 hours per week to the nursing home. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 720		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by:	2 875		3/12/25

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2 875	Continued From page 6 Based on interview and document review, the facility failed to complete assessment including, vital signs and general condition, when status change was reported to a nurse for 1 of 3 (R1) residents reviewed for quality of care. Findings include: R1's admission Minimum Data Set (MDS), dated 1/22/25, indicated R1 had diagnoses of multiple sclerosis, sepsis (a serious infection), and acute ischemia of the intestine (when the blood flow to the intestine is suddenly cut off). R1's MDS indicated she required substantial assistance with all activities of daily living (ADLs) and was cognitively intact. R1's care plan, dated 1/22/25, indicated R1 was dependent on staff assistance for bed mobility, dressing and personal hygiene. R1's care plan indicated she was dependent on the assistance of staff to pivot transfer to/from the bed to the wheelchair or commode. A Physicians Order for Life Sustaining Treatment (POLST), dated 1/21/25, indicated R1 wanted cardiopulmonary resuscitation (CPR) attempted, if she had no pulse and was not breathing. A progress note on 2/8/25 at 4:15 p.m., indicated R1 was ill that morning with nausea and vomiting and "did not keep her pills down". R1 continued to have vomiting and diarrhea throughout the day. R1 refused all meals and told nursing assistant (NA)-A she did not feel well. When NA-A provided cares around 1:00 p.m., R1 was alert and talking. NA-B observed R1 to have a nosebleed around 3:30 p.m. and became unresponsive. 911 was called. At 3:44 p.m. R1 became blue and had no	2 875	Corrected.	

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2 875	Continued From page 7 pulse. Registered nurse (RN)-A started CPR. RN-A began CPR and sent staff to get the AED (automated external defibrillator, device used to analyze heart rhythm and deliver electric shock to restore normal rhythm during cardiac arrest). AED was applied and shock was not advised. CPR resumed for three cycles of CPR and analyzing via the AED. R1 still didn't have a pulse and was bleeding from the nose and mouth. CPR ceased when ambulance arrived. Emergency medical services (EMS) staff hooked resident up to their monitor. R1 was asystole (a cardiac arrest rhythm where the heart's electrical and mechanical activity stops completely). Director of nursing (DON) Jessica was notified. R1's progress notes lacked notification to the provider of R1's deterioration in condition prior to her death. On 2/13/25 at 1:33 p.m., NA-C stated he was working on 2/8/25. NA-C stated he assisted RN-A and NA-B in CPR efforts for R1. NA-C stated he could not remember how long they performed CPR. NA-C stated EMS staff asked RN-A why they stopped CPR and RN-A replied, "she died." On 2/13/25 at 2:04 p.m., RN-A stated she worked from 6:00 a.m. to 6:30 p.m. on 2/8/25. R1 had nausea, vomiting, and diarrhea all day. RN-A stated she became aware of R1's change in condition around 7:45 a.m. when R1 vomited after taking her morning medications. RN-A stated R1 refused breakfast and lunch. She did not contact R1's provider because it was a Saturday. She did not do a physical assessment to further investigate R1's change in condition and did not take her vital signs (blood pressure, temperature, pulse, and respiratory rate). RN-A stated R1 had a nosebleed and became	2 875		

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	00939	A. BUILDING: _____ B. WING _____	02/14/2025

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2 875	Continued From page 8 unresponsive around 3:00 p.m. RN-A stated she called 911 and then started CPR. RN-A stated she could not recall a timeline. The staff completed two-to-three cycles of CPR with AED in place. RN-A stated, "When they (EMS) got there, we kind of stopped." When asked if CPR should be discontinued prior to EMS taking over, RN-A replied, "probably not." On 2/13/25 at 3:09 p.m., the DON stated she was informed CPR was performed on R1 on 2/8/25. The DON stated RN-A told her EMS staff took over when they arrived. The DON stated she would not expect CPR to cease prior to EMS taking over. On 2/13/25 at 3:45 p.m., EMS-A stated a NA met the EMS staff at the door, upon their arrival, stating CPR was in progress. EMS-A stated when they entered R1's room, nobody was doing CPR and RN-A was removing her gloves and stated, "I am done doing CPR. She is gone." EMS-A stated the AED was out and the pads were on R1's chest. EMS-A stated she would not have expected CPR to cease prior to their arrival. On 2/13/25 at 4:18 p.m., EMS-B stated as she was entering the facility with equipment, EMS-A met her in the hall to inform her staff discontinued CPR. EMS-B stated she was surprised CPR was discontinued as it is usually continued until EMS takes over. EMS-B stated RN-A told her 5 cycles of CPR were completed, which would be approximately ten minutes. EMS-B stated they applied the pads of their equipment to determine R1 was "asystole and pupils were fixed and dilated." On 2/13/25 at 5:35 p.m. nursing assistant (NA)-A stated, on 2/8/25, he informed RN-A around 7:00	2 875		

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2 875	Continued From page 9 a.m., R1 was not feeling well. NA-A informed RN-A, R1 had vomiting and diarrhea. R1 had several more episodes of vomiting and diarrhea. R1 refused her breakfast and her lunch. NA-A stated he informed RN-A of these concerns throughout his shift (6:00 a.m. - 2:30 p.m.). On 2/14/25 at 10:12 a.m., NA-B stated she checked on R1 around 3:30 p.m. on 2/8/25. NA-B observed blood coming from R1's nose. RN-A came into the room and said she was going to call 911. NA-B stated she was preparing to wash R1 to get her ready to go to the hospital when she observed R1 was no longer breathing. NA-B stated the head of R1's bed was lowered, and she went to gather the crash cart and AED. When she returned to the room, RN-A was performing CPR on R1. NA-B stated she applied the AED pads and the AED said not to shock R1. They performed two cycles of analyzing with the AED. RN-A was using the ambu-bag (a device used to deliver breaths to a person) to deliver breaths while they did compressions. NA-B stated NA-C assisted with compressions. NA-B stated she exited R1's room when she saw the ambulance in the parking lot and met the EMS staff at the door. NA-B informed EMS staff CPR was in progress. When NA-B and EMS staff returned to R1's room, the staff were no longer performing CPR. NA-B stated she did not know why CPR was stopped. RN-A just stated they stopped. NA-B stated she heard EMS staff asking RN-A why they stopped doing CPR. NA-B stated R1 was on a hospital bed, with a mattress, while CPR was performed. NA-B stated there was a CPR board on the crash cart, but it was never placed under R1. She stated "nobody thought to grab it." On 2/14/25 at 10:53 a.m., the director DON stated RN-A should have updated the provider	2 875		

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2 875	Continued From page 10 with R1's change in condition on 2/8/25 after she vomited her morning medications. The DON stated she expected vital signs and assessment should have been completed "more than once" throughout the day. On 2/14/25 at 2:39 p.m. the medical director (MD) stated he would have expected RN-A to have completed an assessment and vital signs when she started to show signs of illness. Based on the findings, he would expect RN-A would have had communication with the provider to evaluate R1's condition. On 2/14/25 at 2:50 p.m., the nurse practitioner (NP) stated he saw R1 on 2/6/25 and she did not have any of the symptoms noted in the progress note dated 2/8/25. The NP stated he would have expected RN-A to complete and assessment with vital signs. He stated RN-A did not inform him of R1's change in condition on 2/8/25. The NP stated there is always a provider on-call to address the needs of the residents. A facility document, Notification of Changes, dated 8/24, directed the facility promptly informs the resident, consults the physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. 2) Significant change in the resident's physical, mental, or psychosocial condition such as a deterioration in health, mental, or psychosocial status. This may include clinical complications. 3) Circumstances that require need to alter treatment. This may include acute condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 875		

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2 875	Continued From page 11 review facility policy and procedures on frequency of taking resident's vital signs. The DON or designee could provide education on these policies and procedures to all nursing staff. The DON or designee could conduct audits of resident vital signs, and report the results of these audits to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		