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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 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 [DATE], 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 [DATE], 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 [DATE], indicated R1 wanted cardiopulmonary resuscitation (CPR) attempted, if she had no pulse and was not breathing. A progress note on [DATE] 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 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. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:33 p.m., NA-C stated he was working on [DATE]. 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 [DATE] at 2:04 p.m., RN-A stated she worked from 6:00 a.m. to 6:30 p.m. on [DATE]. 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) 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 [DATE] at 3:09 p.m., the DON stated she was informed CPR was performed on R1 on [DATE]. 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 [DATE] 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 [DATE] 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 [DATE] at 5:35 p.m. nursing assistant (NA)-A stated, on [DATE], 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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:12 a.m., NA-B stated she checked on R1 around 3:30 p.m. on [DATE]. 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 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 [DATE] at 10:53 a.m., the director DON stated RN-A should have updated the provider with R1's change in condition on [DATE] 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 [DATE] 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 [DATE] at 2:50 p.m., the nurse practitioner (NP) stated he saw R1 on [DATE] and she did not have any of the symptoms noted in the progress note dated [DATE]. 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 [DATE]. The NP stated there is always a provider on-call to address the needs of the residents. A facility document, Notification of Changes, dated ,d+[DATE], 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.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47083 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.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47083 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 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 was requested, but not received.