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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olivia Restorative Care Center	1003 West Maple Avenue Olivia, MN 56277

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement their Abuse, Neglect, and Exploitation and Elopements and Wandering Resident policy for 1 of 3 (R1) residents reviewed for elopement. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, was independent with activities of daily living and mobility, did not have any behaviors of wandering, exit seeking, and did not wear any exit alarms. During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a wanderguard on his left ankle under his sock. R1 indicated a couple of days prior he was able to flee the facility and was gone for about an hour before the cops busted him and made him go back to the facility. R1 further identified, he used a fingernail file to cut his bracelet (wanderguard) off his ankle; had breakfast, no one had noticed his bracelet was off and he watched the door until no one was watching; he pushed the door open, and stated, he seized the opportunity. R1 stated he intended to walk to a neighboring town about thirty miles away to a place where he knew a friend would be, and then get the friend to take him home. R1 further stated he did not like being in the facility, and had no intention of ever returning to the facility, but the cops made him go back. R1 further identified the facility put another bracelet on his ankle to keep him in, but he had gotten out before and was planning to attempt it again. But the next time he would bring a club so no one could get close enough to take him back to the facility. R1 further explained a couple of months prior he had cut his wanderguard off and got out. He stated he was gone for about 20 minutes before the staff noticed. R1 then stated, They don't like me here, I am trouble, and I am very angry about having to be here [in the facility]. R1's medical record was reviewed and lacked any documentation related to the reported elopement attempts. Review of facility incident reports did not include any risk management, incident reports, or investigations related to the reported elopement attempts. The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R1's reported elopement attempts on 2/23/25 or 5/5/25. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Olivia Restorative Care Center	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 1:10 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and not able to be outside without staff. On 5/5/25, staff last saw R1 eating breakfast, but not sure what time that was. When NA-B was going to administer his medications, she could not find him. Staff searched the facility, and police called in to say someone in the community found him and called them. R1 wears a wanderguard and cannot go outside alone but stated, He [R1] is sneaky and will sit by the door until another resident goes out and try to get out with them. During an interview on 5/7/25 at 1:45 p.m., NA-B stated on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him. She noted R1's walker to be parked by the front door. The director of nursing (DON) got a phone call about 8:50a.m. - 8:55 a.m. that someone had found R1 on the other side of town and called the police. NA-B sated R1 had gotten very, very, very far from the facility and it was a long way to walk. During an interview on 5/7/25 at 3:07 p.m., regisitred nurse (RN)-B stated on 5/5/25, R1 was at breakfast and all of a sudden he was gone. R1 talked to her when he returned and was upset. R1 explained to RN-B that he wanted to get home, so he went downtown and crossed the highway with the intention to walking to his hometown. RN-B further identified R1 had been planning this [elopement] and watched the door until no one was around and booked it. RN-B identified she did not know if the facility filed a report to the SA. During an interview on 5/8/25 at 10:47 a.m., community member (CM) stated on 5/5/25 at approximately 8:45 a.m., she noted an elderly gentleman, later identified as R1, walking in a residential area about a block away from a major highway. CM stated R1 looked lost and approached him as he was crossing the street. CM further stated R1 was determined to get to [NAME] [neighboring town about 30 miles away] by walking along that highway. The CM walked about a block visiting with R1, and learned that he was a resident of the facility and did not intend to go back to the facility. The CM then stepped away to call the police department and they were unaware of any missing persons from the facility. The CM identified the residential neighborhood that R1 was found in was about 12 blocks from the facility, and the route included crossing over a busy major highway and a railroad track, and R1 wanted to get to another highway to walk thirty miles to his destination. During an interview on 5/9/25 at 2:35 p.m., police officer (PO) stated on 5/5/25 at 8:50 a.m., the police department received a call that an elderly man (identified as R1) was walking about 12 blocks away from the facility while attempting to walk to [NAME]. The PO also indicated R1 had eloped from the facility previously on 2/23/25, but the facility found him before the police responded, so the facility cancelled the call. From the police notes, it indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks and footprints in the snow and was able to locate him. No other information was available due to the facility cancelling the call before the officers responded. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility polic Abuse, Neglect, and Exploitation dated 4/25/25, defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also identified the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies withing specified timeframes of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury or not later that 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final withing 5 [five] working days of the incident, as required by state agencies. During an interview on 5/8/25 at 4:24 p.m., director of nursing (DON) indicated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff that R1 was not in the building. The DON further explained R1 signed his name in the sign-out book but did not have a time or date when he left so they started to get worried about him and the police returned him to the facility shortly after they realized R1 was gone. The DON stated the IDT team debated about reporting the elopement to the SA during a meeting on 5/6/25 and it was determined R1 did not elope so did not investigate or report it to the SA. The DON indicated she was not aware of R1's 2/23/25 elopement attempt and did not know if it was investigated or reported to the SA. During an interview on 5/8/25 at 9:45 a.m., the administrator indicated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. that they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his wanderguard off. The administrator indicated he did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, it [elopement] wasn't on my radar. The administrator did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the state agency (SA) but the elopement was not investigated or reported and was unaware of any of R1's previous elopements from the facility. Review of the facility's policy titled, Abuse, Neglect, and Exploitation dated 4/25/25 defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy identified the following: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. • Investigate different types of alleged violations. • Identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. • (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and • Providing complete and thorough documentation of the investigation. Protection of the Resident to include: • Examining the alleged victim for any sign of injury, including physical examination or psychosocial assessment if needed. • Increased supervision of the alleged victim and residents • Room or staffing changes, if necessary, to protect the residents • Providing emotional support and counseling the resident during and after the investigation, as needed; • Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. Reporting/Response to include: • the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies withing specified timeframes of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final withing 5 [five] working days of the incident, as required by state agencies. • (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Take all necessary actions as a result if [of] the investigation, which may include, but are not limited to the following: • Analyzing the occurrence(s) to determine why abuse, neglect, occurred and what changes are needed to prevent further recurrences. • Defining how care provision will be changed and/or implemented to protect residents receiving services. • Training of staff on changes made and demonstration of staff competency after training is implemented. • Identification of person responsible for monitoring implementation of the plan. • The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure an elopement from the facility was recognized and reported to the State Agency (SA) for 1 of 1 resident (R1) reviewed for elopement. Findings include: During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a WanderGuard (a bracelet wander management system that ensures resident safety with customizable door access) on his left ankle under his sock. R1 stated a couple of days prior he was able to flee the facility, and was gone for about an hour before the cops busted him and made him go back to the facility. He used a fingernail file to cut his bracelet (WanderGuard) off his ankle; had breakfast, and no one had noticed his bracelet was off. He watched the door until no one was watching, and pushed the front entry door open. I seized the opportunity and walked out. He intended to walk to a neighboring town about thirty miles away, to a place where he knew a friend would take him home. He did not like being in the facility, and had no intention of ever returning to the facility, but the cops made him go back. The facility put another bracelet on his ankle to keep him in, but he had gotten out before, and was planning to attempt it again. The next time he would bring a club so no one could get close enough to take me back to the facility. A couple of months prior, he had cut off his WanderGuard and gotten out of the facility. He was gone for about 20 minutes and made it about 8 blocks in the snow before the staff noticed he was gone. R1's medical record was reviewed and lacked any documentation related to the reported elopement attempts. Review of facility incident reports lacked any risk management or incident reports related to the reported elopement attempts. The Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R1's reported elopement attempts on 2/23/25 or 5/5/25. R1's Elopement Risk assessment dated [DATE] indicated R1 was at risk for elopement related to his habit of wandering or attempting to leave the building, asking to go home or other specific destinations, diagnoses of dementia, and eloping from this setting or a previous setting. Other risks included R1's family voicing concerns he may have a tendency to wander or elope, and he took medications that could cause confusion. Interventions implemented were recreational activities of interest, check in and out log, staff awareness of elopement risk, personalization of room and WanderGuard in place on R1's ankle. During an interview on 5/7/25 at 1:10 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and not able to be outside without staff. On 5/5/25, R1 was last seen eating breakfast and when NA-B was going to administer his medications, she could not find him. A search of the facility was done, and police called in to say someone in the community had found R1 and called them. R1 wore a WanderGuard and could not go outside alone but he is sneaky and will sit by the door until another resident goes out and try to get out with them. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 1:45 p.m., NA-B stated on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him. She noted R1's walker to be parked by the front door. The director of nursing (DON) received a phone call about 8:50 a.m. to 8:55 a.m. which said someone had found R1 on the other side of town, and called the police. R1 had gotten very, very, very far from the facility, and it was a long way to walk. During an interview on 5/7/25 at 3:07 p.m., RN-B stated on 5/5/25 R1 was at breakfast and all of a sudden he was gone. R1 talked to her when he returned, and he was upset. He explained to her he wanted to get home, so he went downtown and crossed the highway with the intention to walking to his hometown. R1 had been planning this [elopement] and watched the door until no one was around and booked it. She did not know if the facility filed a report to the SA. During an interview on 5/8/25 at 4:24 p.m., the DON stated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff R1 was not in the building. R1 signed his name in the sign-out book, but did not have a time or date when he left. They started to get worried about him, and the police returned him to the facility shortly after they realized he was gone. The IDT team debated about reporting the elopement to the SA during a meeting on 5/6/25, and it was determined R1 did not elope, so it was not reported. She was not aware of R1's 2/23/25 elopement attempt, and did not know if a report to the SA was filed. During an interview on 5/8/25 at 9:45 a.m., the administrator stated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his WanderGuard off. He did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, it [elopement] wasn't on my radar. He did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the SA, but the elopement was not reported. He was unaware of any of R1's previous elopements from the facility, and did not know if nursing did an assessment to determine if R1 was safe to be outside unsupervised. The undated facility policy Elopement and Wandering Residents defined elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Compliance guidelines include alarms are not a replacement for necessary supervision. The facility policy Abuse, Neglect, and Exploitation dated 4/25/25, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also identified the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and all other required agencies within specified time frames of immediately, but not later than 2 [two] hours after the allegation is made, if the events of the allegation involves abuse or result in serious bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury. The administrator will follow up with the government agencies, during business hours, to the confirm the initial report was received, and to report the results of the investigation when final within 5 [five] working days of the incident, as required by state agencies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess supervision needs, develop individualized person-centered interventions to mitigate risks and hazards for 1 of 3 residents (R1) reviewed for elopement risk. This resulted in an immediate jeopardy (IJ) when R1 left the facilty without staff knowledge and was found 12 blocks away, unharmed by a community member. The immediate jeopardy began on 5/5/25 when R1 left the facility and was found by a community member several blocks away confused, and returned to the facility by local police. The IJ was identified on 5/8/25. The administrator, director of nursing (DON), director of operations, and director of clinical operations were notified of the immediate jeopardy on 5/8/25 at 5:10 p.m. The immediate jeopardy was removed on 5/12/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's hospital Discharge Placement Referral dated 1/14/25, indicated R1 required long term care placement due to not being safe or able to care for self at home. The referral further indicated R1's memory is poor, thinking is delusional, and family was in the process of getting power of attorney and working with Adult Protective Services on placement. R1's Medical Diagnoses report dated 1/15/25, identified R1 had diagnoses of lumbar spondylosis (degeneration of the lumbar spine), disorientation, moderate dementia with behavioral disturbance, hypertension, weakness, right shoulder arthritis, and macular degeneration (medical condition that causes blurred vision or no vision in the center field). R1's Care Plan Report focus initiated 1/17/25, identified R1 has moderate dementia with behavioral disturbance and was an elopement risk/wanderer related to impaired safety awareness. Intervention history included on 2/4/25, Wanderguard was placed on R1's right ankle to alert staff if attempting to leave the building on his own; on 4/17/25, Wanderguard placed on R1's walker. In review of R1's record between 1/17/25 through 4/17/25, the record did not include an assessment or notation of rationale for the implementation of the Wanderguard that was placed on 2/4/25 on R1's right ankle nor why it was changed to his walker on 4/17/25. During an interview on 5/9/25 at 2:35 p.m., police officer (PO) indicated R1 had eloped from the facility previously on 2/23/25 but the facility found him before the police responded so the facility cancelled the call. PO stated the report indicated R1 was very confused, eloped from the facility, a nurse followed R1's walker tracks in the snow and were able to locate him. No other information was available due to the call being cancelled by the facility. Review of R1's record did not identify an accounting of this incident, nor were there updated interventions reflected in the care plan after R1 eloped in February 2025. Further there was no indication the facility completed an incident report with an investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Fall Risk assessment dated [DATE], indicated R1 was at high risk for falls due to R1's intermittent confusion, balance problem while walking and standing, use of assistive devices, and took three to four high risk medications. R1's ROM (range of motion) and Mobility assessment dated [DATE], identified R1 had impairment of one upper extremity, was steady with walking at all times, and used a walker. R1's Elopement Risk assessment dated [DATE], indicated R1 was at risk for elopement related to R1's habit of wandering or attempting to leave the building, asking to go home or other specific destinations, diagnoses of dementia, eloping from this setting or a previous setting. R1's family voicing concerns that the resident may have a tendency to wander or elope, and taking medications that could cause confusion. Interventions implemented were recreational activities of interest, check in and out log, staff awareness of elopement risk, personalization of room and Wanderguard (bracelet wander management system that ensures resident safety with customizable door access) in place on R1's ankle. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, was independent with activities of daily living and mobility, did not have any behaviors of wandering, exit seeking, and did not wear any exit alarms even though the facility elopement assessment identifed R1 was at risk and had a wanderguard alarm. R1's progress notes dated 5/1/25, at 11:56 a.m., R1 was exit seeking in the morning, stating he wanted to go home, needed to go to the bank. At 10:00 a.m., had coat on and attempted to leave facility when another resident opened the front door. Staff redirected and told social service designee (SSD). R1 stated he was going to walk to the (out of town] bank. R1 did have a Wanderguard on and door did lock when resident was walking to chair by front entry. Review of R1's record did not include a comprehensive assessment of R1's risk for elopement for appropriate interventions including level of supervision following the elopement attempt on 5/1/25. Further, no indication R1's care plan interventions were re-evaluated for effectiveness and/or new interventions were developed and implemented to prevent or mitigate the risk for R1 to elope. In addition, R1's record did not include a comprehensive cognitive assessment that would identify R1's functional capacity for safe decision making and/or identify R1's ability to be safe in the community independently. A vulnerable adult report submitted to the State Agency dated 5/6/25 indicated on the morning on 5/5/25 R1 had been walking on a sidewalk looking lost as he crossed an intersection. R1 had planned to walk back to his home (approximately 30 miles away). Local law enforcement was contacted. Review of Facility event/incidents reports did not include a report nor an investigation for R1's elopement on 5/5/25. Furthermore, there was no accounting of the elopement in R1's record nor evident a comprehensive assessment completed and there was no care plan updates/revisions prior to the start of the survey on 5/7/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation and interview on 5/7/25 at 3:45 p.m., R1 was observed lying in bed with a Wanderguard on his left ankle under his sock. R1 indicated a couple of days ago (5/5/25) he was able to flee the facility and was gone for about an hour before the cops busted him and made him go back to the facility. R1 used a fingernail file to cut his bracelet (Wanderguard) off his ankle and went for breakfast. No one had noticed his bracelet was off. He watched the door until no one was watching, he pushed the door open, and seized the opportunity. R1 had intended to walk to a neighboring town about thirty miles away to a place where he knew a friend would be and then get the friend to take him home. R1 did not like being in the facility and had no intention of ever returning to the facility, but the cops made him go back. Then the facility put another bracelet on his ankle to keep him in, but he had gotten out before and was planning to attempt it again. The next time he would bring a club so no one could get close enough to take him back to the facility. R1 further explained a couple of months prior he had cut his Wanderguard off and got out and that time he was gone for about 20 minutes before the staff noticed. R1 then stated, they don't like me here, I am trouble, and I am very angry about having to be here [in the facility]. During an interview on 5/8/25 at 10:47 a.m., community member (CM) indicated on 5/5/25 at approximately 8:45 a.m., she noted an elderly gentleman, later identified as R1, walking in a residential area about a block away from a major highway. CM stated, R1 looked lost and approached him as he was crossing the street. CM further indicated R1 was determined to get to [NAME] [neighboring town about 30 miles away] by walking along that highway. The CM walked about a block visiting with R1 and learned that he was a resident of the facility and did not intend to go back to the facility. CM then called the police, and they were unaware of any missing persons from the facility. CM identified the residential neighborhood that R1 was found in was about 12 blocks from the facility and the route included crossing over a busy major highway and a railroad tracks. During an interview on 5/9/25 at 2:35 p.m., police officer (PO) identified on 5/5/25 at 8:50 a.m., the police department received a call that an elderly man (identified as R1) walking about 12 blocks away from the facility while attempting to walk to [NAME]. R1 did not want to go back to the nursing home but, the PO did not feel R1 was safe to be walking in the community without his walker. R1 would have had to cross the railroad tracks and the major highway to get to that location he was found at. During an interview on 5/8/25 at 8:45 a.m., family member (FM)-A denied notification by the facility of R1's elopement on 5/5/25 and this was her first knowledge of the incident. FM-A stated, I am not surprised, it's not his first time escaping the facility. FM-A indicated the first time R1 eloped, it was winter, and staff found him about 7-8 blocks from the facility and further stated, he [R1] is absolutely not safe to be out of the building [facility] on his own. FM-A identified R1 was admitted to the facility because he was having delusional thoughts, paranoia, and erratic behavior due to his dementia. R1 was not safe to live independently anymore and needed 24-hour supervision. During an interview on 5/7/25 at 12:40 p.m., nursing assistant (NA-C) indicated R1 was not safe to go outside without staff supervision. R1 liked to sit by the front entry and when a family member or another resident went outside, R1 would go out too and staff would bring him back in. (continued on next page)

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olivia Restorative Care Center	1003 West Maple Avenue Olivia, MN 56277

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/7/25 at 1:10 p.m., NA-A, indicated R1 was an elopement risk and not able to be outside without staff. R1 wore a Wanderguard and cannot go outside alone but stated, he [R1] is sneaky and would sit by the door until another resident went out and would try to get out with them. On 5/5/25, R1 was last seen eating breakfast but not sure what time that was. When NA-B was going to administer his medications, she could not find him. A search of the facility was done. The police called the facility to inform them R1 was found by someone in the community. During an interview on 5/7/25 at 1:45 p.m., NA-B identified on 5/5/25 at approximately 8:40 a.m., she was looking for R1 to administer his morning medications and could not find him but noted R1's walker to be parked by the front door. The director of nursing got a phone call at 8:50am - 8:55 a.m. that someone had found R1 on the other side of town and called the police. NA-B further stated R1 was an elopement risk and had a Wanderguard bracelet on but did not have the Wanderguard on him when the police brought him back. NA-B stated two nail clippers were found in R1's room so he must have cut off his Wanderguard again. NA-B further explained R1 had almost cut it off on the evening shift a while ago but could not recall when it happened. NA-B sated R1 had gotten very, very, very far from the facility this last time and it was a long way to walk. During an interview on 5/7/25 at 1:19 p.m., licensed practical nurse (LPN)-A, indicated the morning of 5/5/25, maintenance staff told her R1 was gone and we needed to look for him. LPN-A could not remember the time this was reported to her. LPN-A identified R1 wore a Wanderguard which meant he had to be supervised if he goes out of the facility. The police returned R1 to the facility and R1 was on 15-minute checks but was not sure where those checks were documented or who did them. During an interview on 5/7/25 at 2:00 p.m., registered nurse (RN)-A indicated she was not in the facility when R1 eloped on 5/5/25 but interdisciplinary team (IDT) discussed the incident on 5/6/25 and a Wanderguard had been put back on R1. RN-A indicated R1 always wanted to go home but was an elopement risk and not safe to go outside without supervision. During an interview on 5/7/25 at 2:20 p.m., health unit coordinator (HUC) indicated on 5/5/25 at approximately 8:10 a.m. the DON told him to look for R1, so he drove his car around town to try to find him, but the police brought R1 back. HUC further identified R1 was an elopement risk and could not go outside independently so R1 wore a Wanderguard so the doors would alarm if he left the facility. During an interview on 5/7/25 at 3:07 p.m., RN-B indicated on 5/5/25, R1 was at breakfast and, all of a sudden he was gone. R1 talked to her when he returned to the facility, he was very upset. R1 explained to RN-B that he wanted to get home so he went downtown and crossed the highway with the intention to walk to his hometown. RN-B further identified R1 had been planning this [elopement] and watched the door until no one was around and booked it. The only intervention that was communicated after the elopement was that another Wanderguard was placed on R1's ankle and some forks and a razor were taken out of his room. During an interview on 5/8/25 at 4:18 p.m., NA- D identified R1 could not go outside unsupervised because R1 was not safe alone in the community because he may fall with no one around to help. During an interview on 5/8/25 at 4:28 p.m., NA-E indicated R1 can go outside only if staff are with him because if R1 were to go outside by himself, he could take off again and get confused, dehydrated, or get hit by a car. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/8/25 at 4:52 p.m., NA-G indicated R1 has a Wanderguard bracelet on his ankle which meant he could not go outside without staff. R1 was not safe to go outside, he could elope again and not be found. During an interview on 5/8/25 at 1:45 a.m., the social service designee (SSD) indicated R1 signed his name in the sign out book, so SSD did not consider R1 leaving the facility unsupervised and without staff knowledge an elopement. SSD identified R1 as an elopement risk but did not consider him a high elopement risk and stated, everyone in the facility is an elopement risk. The SSD then indicated she did not know whether R1 had an assessment completed to determine if he was safe in the community without supervision and did not know why R1 wore a Wanderguard. The SSD said R1 has the right to be out in the community and he had intentions of returning to his hometown to be on the planning committee for the hometown celebration and parade. SSD stated it was not safe for anyone to walk the highway, not even herself. During an interview on 5/8/25 at 4:24 p.m., director of nursing (DON) indicated on 5/5/25 at approximately 8:45 a.m., she was alerted by staff that R1 was not in the building. The DON further explained R1 signed his name in the sign-out book but did not have a time or date when he left so they started to get worried about him and the police returned him to the facility shortly after they realized R1 was gone. The DON stated the IDT team debated about it during a meeting on 5/6/25 and it was determined R1 had a BIMS (brief interview for mental status) of 12 [moderately impaired cognition], was able to make his needs known, signed out in the book so did not feel it was an elopement. The Wanderguard was just to alert staff that he was going outside by himself because he will try to leave without signing out approximately monthly. The DON indicated the IDT has debated on whether R1 was safe to be outside on his own and it was not clear. DON indicated there was not an assessment completed to determine if R1 was safe in the community without supervision. During an interview on 5/8/25 at 9:45 a.m., the administrator indicated the facility notified him by phone on 5/5/25 at approximately 8:45 a.m. that they were looking for R1, but the police found him and brought him back to the facility. R1 had cut his Wanderguard off but he could sign himself out and go out of the facility independently. Administrator indicated he did not consider the incident an elopement because R1 was returned by police shortly after the staff noticed him missing and stated, it [elopement] wasn't on my radar. The administrator indicated he did not know the details of R1 getting out of the facility unnoticed, but they removed the fingernail clippers from R1's room, changed the door code, and have the front door always locked now. The administrator did clarify a resident leaving the facility without staff knowledge would be an elopement and reportable to the state agency (SA) but the elopement was not reported and was unaware of any of R1's previous elopements from the facility and did not know if nursing did an assessment to determine if R1 was safe to be outside unsupervised. The undated facility policy titled Elopement and Wandering Residents, included the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy defines elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Compliance guidelines include alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Procedure post-elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative. c. A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults. d. The resident and family/authorized representative will be included in the plan of care. e. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. g. Documentation in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. The immediate jeopardy that began on 5/5/25, was removed on 5/12/25, when the facility reviewed R1 for a Safety Plan through determination of an elopement risk assessment and a SLUMS; review by IDT, R1 received 1:1 staff supervision; R4 remained in the facility until cognitive and safety assessments and interventions had been determined and a safety plan implemented; reviewed elopement assessments of all residents; care plan were reviewed for appropriate interventions; resident care plans reviewed and revised; DON or designee educated staff on procedures pertaining to residents leaving the facility, missing persons, elopement, and Wanderguard system; nurses received education on comprehensively assessing and reviewing residents for safety in regards to elopement, falls, and cognitive impairment prior to working their next shift. , but the noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.