

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Olivia Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 West Maple Avenue Olivia, MN 56277	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to have a system to ensure residents who were cognitively intact, and not an elopement risk could freely enter and exit the facility for 1 of 1 residents (R5) reviewed for resident rights.</p> <p>Findings include:</p> <p>R5' Face sheet dated 5/27/25, indicated R5 was admitted to the facility on [DATE] and his diagnoses included osteonecrosis (death of bone tissue due to a lack of blood supply) and alcohol dependence.</p> <p>R5's Elopement Risk Evaluation dated 5/23/25, indicated R1 was not at risk for elopement and current interventions included a check in and out log.</p> <p>R5's care plan dated 5/23/25, indicated resident was a low elopement risk and was a smoker. Further, R5's care plan indicated he was independent with locomotion in his wheelchair.</p> <p>On 5/27/25 at 11:50 a.m., upon entering the facility, the entrance door was observed to be locked and there was a doorbell to ring. Staff appeared and typed in a code to unlock the door.</p> <p>On 5/29/25 at 9:49 a.m., R5 was observed sitting the entry way of the front door in his wheelchair waiting for staff to come unlock the door to come back into the facility. Writer went to grab the health unit coordinator (HUC) to let R5 into the facility.</p> <p>On 5/27/25 at 2:13 p.m., R5 approached writer and appeared to be frustrated. R5 stated the facility was like a psych ward, its locked and he had to sign in and out like prisoner.</p> <p>On 5/27/25 at 5:12 p.m., director of nursing (DON) stated the front entrance used to be unlocked, however since admitting more wanderers, we now always lock the front door and require the assistance of staff typing in a code to unlock it, or it will release after 15 seconds as well per fire code. Further, DON stated for cognitively intact residents who were not at risk for eloping, those residents would need to seek out staff assistance to unlock the door.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245290
		If continuation sheet Page 1 of 8

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Restraint Free Environment revised 4/21/25, indicated each resident shall attain and maintain his/her highest practical well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. Further, the policy indicated the resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide assessed supervision needs for 2 of 3 residents (R1, R4) who were at risk for elopement. R1 was able to leave the facility undetected for one hour despite having a wander guard on, which resulted in an immediate jeopardy (IJ).</p> <p>The IJ began on 5/21/25, when R1, while wearing a wander guard bracelet, successfully eloped from the building without the alarm sounding. R1 was allowed out of the locked front entrance by an unknown responsible party (had the pin code to the locked door), crossed a highway, and was found by community members approximately one mile from the facility an hour later, winded but unharmed. The administrator, director of nursing (DON), and nurse consultant were notified of the immediate jeopardy on 5/29/25 at 9:30 a. m. The immediate jeopardy was removed on 5/29/25, but noncompliance remained at the lower score and severity of D, which indicated no actual harm with potential for more than minimal harm which is not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 required a walker for mobility and had moderately impaired cognition.</p> <p>R1's care plan, as of 5/27/25, indicated R1 was at risk for elopement related to diagnoses of disorientation, dementia, weakness and as evidenced by comments and attempts to leave the facility, anger outbursts, use of a wander guard, impaired safety awareness, and independence with ambulation. Further, R1's care plan directed staff to: distract resident from wandering by offering pleasant diversions, structured activities of interest, food/fluids, conversation, television books and personalization of resident room. To reduce likelihood of R1 removing wander guard, remove sharp objects from room such as razors, toe nail clippers, forks, knives, and do not allow him to have scissors; resident is on a one-to-one staff until further notice starting on 5/21/25; rights is a high risk elopement; resident was able to leave the property with direct supervision and was not able to leave the facility alone; resident needs direct supervision when outside; and wander guard placed on resident's ankle.</p> <p>Review of facility report number 360612 to the State Agency dated 5/21/25, revealed R1 was looking to acquire a ride to the VA (Veteran Affairs) office to get his benefits. The VA office was on [NAME] (a street located in Minneapolis) and the VA office was in the Government Center. The facility investigation, revealed R1 had left the facility after 9:30 a.m. and walked to the Government Center. The Government Center notified staff of R1 being there at roughly 10:15 a.m. R1 was in the building. R1 returned to the facility agitated, was assessed for injury, and none noted. Further, R1 eloped as he removed himself from the facility and made his way out of the safe zone to a building in town. Conclusion was R1 left the building at the same time as another resident being brought out for an appointment, despite being on 15 minute checks</p> <p>R1's Visual Check Sheet every 15-minutes dated 5/21/25, revealed at 9:30 a.m., R1 was observed to be in his bedroom and then the front door. From 9:45 a.m. until 10:45 a.m., there was no record of R1's 15 minute checks being conducted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/27/25 at 3:42 p.m., licensed practical nurse (LPN)-A stated R1 was at risk for elopement, wore a wander guard and often put on his jacket and stated he wanted to go home. LPN-A stated R1 had recently eloped from the facility and walked to the courthouse which was on the highway. LPN-A stated the front entrance was locked and staff were the only ones who know the code to unlock the door to let a visitor or resident out of the building.</p> <p>On 5/27/25 at 4:06 p.m., community member (CM)-A stated one of the custodians at the government center brought R1 into her office and stated he was in the hallway and needed a ride. CM-A stated R1 appeared to be tired and was provided a chair and a glass of water. CM-A stated CM-B called the facility to inform them he was at the Government Center.</p> <p>On 5/27/25 at 4:12 p.m., CM-B stated R1 appeared to be out of breath and tired when he got to the Government Center, he had on shoes but did not have a walker with him. CM-B stated she informed the Sheriff's department at 10:11 a.m. on 5/21/25, and asked if they had any missing persons reports, which they did not. CM-B stated she then called the facility and asked if R1 was a resident there and they confirmed he was. CM-B stated she then informed the facility R1 was at the government center to which staff replied, Oh he is there? We will send someone right there. CM-B stated the facility staff was not aware R1 was not at the facility at the time, which was approximately at 10:30 a.m.</p> <p>On 5/27/25 at 5:12 p.m., DON stated R1 had impaired cognition, was at risk for elopement, and required staff supervision while out of the facility. DON stated she was informed at approximately 10:15 a.m. on 5/21/25, that R1 was not in the building. Further, R1 was on 15-minute safety checks and was last seen by staff at approximately 9:30 a.m., confirming 15-minute checks were not being completed. DON indicated the facility's internal investigation for R1's incident revealed R1 speculated he had to have left with the transportation services as they were in the facility around that time; she also confirmed staff were the only ones who knew the code to open the door, so staff would have had to let the transportation services out of the door and would have seen R1 exit, however no staff would confess.</p> <p>On 5/28/25 at 8:31 a.m., LPN-B stated R1's cognition and safety awareness were impaired. R1 required a walker while ambulating to help stability and was determined to be at high risk for eloping and had a wander guard on his ankle. LPN-B stated she was working with R1 on 5/21/25, the day of the incident, and she last observed R1 at 9:00 a.m. in his room not exhibiting any exit seeking behavior. LPN-B stated she was not aware R1 was missing from the facility until the administrator was notified. Further, LPN-B indicated R1 required 15-minute safety checks due to his exit seeking behaviors and elopement history, and she had been completing those safety checks until 9:00 a.m. until NA-D was assigned to R1's care but added, NA-D was not aware R1 required 15-minute checks. In addition, LPN-B stated R1 had reported he waited for staff to unlock the front entrance for the transportation driver and he followed the driver out the front door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/28/25 at 9:17 a.m., NA-D stated she was assigned to R1's care on 5/21/25, and that day was also her first shift working at the facility, as she was a contracted agency staff. NA-D stated she was late for her shift that day and arrived at the facility at approximately 6:30 a.m. The previous overnight aid was in a rush to get off her shift, so NA-D stated she did not get any verbal report regarding R1 or his safety checks. NA-D also stated she did not receive training prior to the start of her shift and did not have access to any resident's care plans until management arrived at the facility at approximately 9:00 a.m. NA-D confirmed there was a lack communication by facility staff to NA-D regarding which residents were high risk for elopement. Further, NA-D stated she was unsure of the exact time she last saw R1, but did last see him in his room making his bed prior to taking a break. NA-D was not aware R1 was out of the facility until staff received a call from the government center.</p> <p>Observation on 5/28/25 at 10:01 a.m., R1 was in his room making his bed with a staff member sitting outside in a chair directly outside his room. R1 stated he had been a bad boy and lifted his pant leg to reveal a wander guard on his ankle. Further, R1 stated he had walked right out of the building on 5/21/25 and if he sat and watched long enough staff would open the door and he could take off. R1 stated he walked to the government center, was unsure how far away it was, but denied getting hurt.</p> <p>On 5/28/25 at 11:16 a.m., administrator stated he was made aware of R1's elopement and went to the government center to pick up R1 himself. He indicated the facility's internal investigation determined R1 exited through the front entrance with a visitor or vendor. Administrator stated staff were the only ones who were provided the code, and the only way a visitor or vendor would know the code was if a staff shared it or if they watched a staff input the code. Staff are expected not to share the door codes.</p> <p>On 5/28/25 at 2:17 p.m., NA-E stated she was a contracted agency staff and had worked since 5/21/25. NA-E stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for.</p> <p>On 5/28/25 at 3:33 p.m., LPN-A stated she had not been provided with education recently regarding elopements, residents at risk for elopement or who to not unlock the entrance for since the incident with R1 had occurred. LPN-A stated she was not here the day of the incident but worked on 5/26/25.</p> <p>On 5/28/25 at 3:40 p.m., DON stated she had sent a text message to staff regarding completing the elopement training but had missed sending the message to LPN-A. DON stated she did not provide a date to the staff to have the education completed by, and would be expected to track and ensure all staff have completed the education, but did not have a process in place to do so at this time.</p> <p>The immediate jeopardy that began on 5/21/25, was removed on 5/29/25, and was verified through observation, interview, and document review when the facility implemented the following interventions:</p> <ul style="list-style-type: none"> -R1's care plan was updated to include interventions to deter elopement such as putting on a war movie and talk about farming and [NAME]. -R1 was currently on a one-to-one staff 24 hours a day <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Other 8 residents who were identified as high risk of elopement with wandering tendencies would be updated with wandering interventions and identification of exit seeking behaviors. Care planned interventions would be reviewed with interdisciplinary team and floor staff from all departments on 5/29/25.</p> <p>-Kardex's with interventions for staff who missed the meeting would be printed and distributed to the department managers or designee to review prior to the start of their next shifts</p> <p>-All staff will be educated on Missing Persons, Elopements, Interventions for wandering and door alarms by education video or in-person meeting before their next shift. Education would be completed in the building with all staff members on 5/29/25. Quiz was attached to the video for staff members to submit electronically.</p> <p>-Agency staff members received an educational video that needed to be completed prior to starting the floor. The educational video included Missing Persons, Elopements, Interventions and what to do if the door alarms. Agency staff would notify DON of this being completed prior to their shift.</p> <p>-List of High-Risk Elopement residents would be attached to competency checklists for agency staff to have on their person for information.</p> <p>-A list of high-risk elopement resident was distributed to all departments electronically weekly and with changes for the managers to distribute to their staff members.</p> <p>R4's quarterly MDS dated [DATE], indicated R4 had diagnoses that included dementia, and cognitive communication deficit. R4 had no cognitive impairments and did not exhibit wandering behaviors.</p> <p>R4's care plan dated as of 5/27/25, indicated R4 was an elopement risk and R4 had a history of attempting to leave the facility. Further, R4's care plan identified R4 as a high risk for elopement, required direct supervision while outside and directed staff to ensure sign in/out log when family was taking resident out of building. R4 had a wander guard on his ankle.</p> <p>Observation on 5/27/25 at 1:42 p.m., an unidentified male resident approached dietary cook (DC)- A and asked DC-A to assist him with unlocking the front door to go outside. DC-A agreed and using a code on the front door, let the resident out of the building along with R4, who followed behind with his walker and was wearing a jacket. The alarm on the door sounded. DC-A closed the door and walked away. DON came out of office, looked outside through the glass door and headed directly outside where she was observed talking to R4 and visitors. Upon her return, DC-A turned around and stated what, was he not supposed to be outside? and continued to walk down the hallway. At 1:45 p.m., DON approached DC-A and stated R4 had family outside but otherwise he was not allowed outside unsupervised. DC-A responded with he was suited up and ready to go, I didn't know.</p> <p>On 5/27/25 at 1:47 p.m., DON stated R4 was assessed to be an elopement risk and required supervision while outside the facility. Today R4 happened to have family sitting outside so was not put at risk when he was let out of the building by DC-A. Further, DON stated elopement risk and interventions were identified in each resident's care plan, however dietary or housekeeping staff do not have access to resident care plans and would need to be notified verbally by their supervisors of residents who were at risk for elopement and required supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Elopement and Wandering Residents, undated, indicated the facility ensure that residents who exhibit wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements, but alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. Further, the facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on interview and document review, the facility failed to ensure contracted resident care staff were competently trained on facility resident procedures, as well as provided access to electronic medical records (EMR) to implement person-centered resident care needs, interventions related to resident care to ensure safety and reduce the risk of complication (i.e. elopement). This had the potential to affect all 46 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On 5/28/25 at 9:17 a.m., nursing assistant (NA)-D stated her first shift working at the facility was on 5/21/25. NA-D stated she received no training for the facility prior to the start of her shift and did not have access to any of the resident's care plans until management arrived at the facility at approximately 9:00 a.m.</p> <p>On 5/28/25 at 3:40 p.m. director of nursing (DON) stated contracted agency staff were expected to complete the packet that was printed and placed at the front desk before they would start working on the floor. Further, DON stated they would be assigned a staff member to assist them with completing the packet and would be given access to the EMR at the beginning of their shift as well. In addition, DON confirmed NA-D did not complete the required training prior to working her shift on 5/21/25.</p> <p>Review of facility policy titled Contract Employees Emergency Preparedness Training, not dated, indicated the facility was to share appropriate information from the facility's emergency plan with contracted employee, however policy did not address receiving access to EMR or education related to other facility policies such as elopements.</p>		