

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 12/03/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report an allegation of abuse timely to law enforcement and the State Agency for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency on 11/23/25, alleged staff to resident sexual abuse when on 11/21/25, R1 reported that on 11/4/25, during his bath, nursing assistant (NA)-A put her fingers in his rectum, washed his genitals too long, and gave him an erection. R1 reported this embarrassed him. This incident was reported to the director of nursing (DON), and assistant director of nursing (ADON) on 11/21/25. The DON verbalized awareness of the alleged abuse and had done an investigation. The report noted the alleged sexual abuse had not been previously reported to law enforcement. R1's quarterly minimum data set (MDS) dated [DATE], identified R1 had intact cognition, required staff assist with transferring, toileting, dressing, and showering. R1 diagnoses included osteonecrosis (death of bone tissue due to lack of blood supply), major depressive disorder, and generalized anxiety disorder. R1's care plan last updated initiated on 5/29/25, identified R1 had a history of traumatic sexual abuse. During an interview on 12/1/25 at 2:05 p.m., the DON indicated she became aware of R1's allegation of abuse on 11/18/25, when she learned that R1 had told multiple staff that NA-A had sexually abused him on 11/14/25. The DON stated she did an investigation but did not report the allegation to the SA or law enforcement as R1 has a history of making false accusations against staff and when interviewed, R1 questioned his perception of the alleged event. During an interview on 12/3/25 at 2:35 p.m., licensed practical nurse (LPN)-A indicated R1 required two staff assist for all cares due to history of allegations LPN-A identified on Monday, 11/17/25, R1 reported that NA-A had him in the shower alone and put her fingers up his butt and he did not know how to interpret it. R1 wanted to talk to the DON. LPN-A stated she reported the allegation to the DON that morning but could not remember what time. During an interview on 12/3/25 at 2:47 p.m., social service designee (SSD) indicated she became aware of the allegation of abuse during the facility's morning meeting on 11/17/25. The SSD stated R1 did have a history of making false accusations against staff but had not made any accusations of sexual abuse by staff in the past that she was aware of. The SSD stated, if it was any other person [resident], we would have reported it [to the SA]. During an interview on 12/3/25 at 3:30 p.m., the administrator indicated he did not know the exact date when he became aware of R1's allegations of abuse but it was the same day as the DON. The administrator stated the facility did not report the allegation to the SA or law enforcement because R1 had a history of manipulation and lies. The administrator further stated if it were any other resident [other than R1], the facility would have reported. The undated Abuse, Neglect, and Exploitation Policy, indicated the facility was to report all alleged violations to the administrator, state agency, adult protective services, and all other required agencies (e.g., law enforcement when applicable) within specific time frames. Immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</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
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