| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245290 | A. Building<br>B. Wing | 09/26/2024 |

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| Olivia Restorative Care Center | 1003 West Maple Avenue<br>Olivia, MN 56277 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>39988<br><br>Based on observation and interview the facility failed to ensure residents were assisted with their meal in a dignified manner for 3 of 6 residents (R1, R11, R23) who were dependent on staff to assist them with meal intake.<br><br>Findings include:<br><br>Observation on 9/23/24 at 12:10 p.m., while in the center dining room nursing assistant (NA)-B was observed to stand next to R1 and give him bites of food. NA-B left R1 and proceeded to obtain another meal for a different resident at which time NA-A was observed to walk over and stand next to R1 and give him bites of food. NA-B returned with R23's meal and proceeded to stand next to her and support her head (she was shaking) while giving her a bite of her food. NA-B and NA-A were observed to visit amoungst each other while standing and giving bites of food to R1 and R23. At 12:24 p.m., NA-C was observed to stand between 2 residents at the table and assist R11 to take a bite of her food. During the meal service NA-A, NA-B, and NA-C were observed to stand the entire time they assisted the residents to eat their meal.<br><br>R1's 8/3/24, quarterly Minimum Data Set (MDS) identified R1 had functional limitations of bilateral upper and lower extremities, he used a wheelchair, and was dependent on staff for eating and all other cares. R1 had diagnoses of hypertension, peripheral vascular disease, and multiple sclerosis. R1 was on scheduled pain medication, was identified to have loss of liquids/solids from mouth when eating or drinking. R1 had weight loss that was not physician prescribed and had a mechanically altered diet.<br><br>R1's 4/9/10, nutritional care plan identified R1 would be provided pleasure foods per request. A decline was anticipated with hospice services in place. Staff were to help set up meal, wash his hands, dispense condiments, and allow to eat meal at own pace. Staff were to provide supervision as needed. R1 had a regular diet with puree texture and nectar thick consistency. He used a lipped plate and nosey cups at meals to assist with independence while eating. The care plan had no mention that R1 was dependent on staff to assist him with his meal intake.<br><br>R11 7/28/24 quarterly MDS identified R11 had severe cognitive impairment, she required substantial assistance for eating and was dependent on staff for all other cares. R11 had diagnoses of hypertension, hyperlipidemia, seizure disorder, anxiety, depression, and Alzheimer's disease. R11 had no nutritional concerns. R11 took a daily antipsychotic and antidepressant.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R11's 11/14/19, nutritional care plan identified R11 received assistance as needed at mealtimes. R11 was on a heart healthy diet, regular texture, and regular consistency.<br><br>R23's 9/13/24, admission MDS identified her cognition was intact, she had no behaviors, she was dependent on staff for eating and all other cares. R23's diagnoses included multiple sclerosis, seizure disorder, malnutrition risk, anxiety, on scheduled pain medication. R23 took a daily antianxiety, antidepressant, and took antibiotic. R23 was being seen by occupational and physical therapy.<br><br>R23's revised 9/23/24, nutritional care plan identified R23 was on a regular diet with regular texture and regular consistency. Staff were to assist by holding resident in position to eat.<br><br>Interview on 9/23/24 at 12:45 p.m., with NA-B identified she stood to feed residents as it made it easier if she had to do something else or assist someone else quick with something. She was unaware of any protocol that staff should sit while assisting residents with eating their meal.<br><br>Interview on 9/23/24 at 12:53 p.m., with director of nursing (DON) identified she chose not to answer if staff should be seated while assisting residents to eat their meal for a more dignified experience or if staff could stand while assisting resident during the entire meal, and reported she would provide me with the facility's policy. She then reported there were times when it would be appropriate for staff to stand and feed a resident such as if the staff are short and the wheelchair was tall. Typically though, she noted, staff should not stand to feed residents. She reported the facility was in process of changing the seating around and that might have had something to do with staff standing to feed residents. She reported there were a lot of residents who need assistance with eating, and the facility staff had just rearranged things and there might have been some confusion that day and felt that may have played a part in staff standing while feeding residents. Additional interview on 9/26/24 at 11:11 a.m., with DON identified the process for R23 was for staff to stand to assist her with her meal intake because of the way staff must support her head while she eats. The DON reported that she added that to R23's care plan. For all other residents staff were to bring them into the dining room and sit down to assist them with their meal intake.<br><br>Review of undated, Meal Supervision and Assistance policy identified residents would be provided adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. The facility would develop and implement, and individualized care plan based on the resident assessment to address the resident's needs and goals. Staff were not to serve the meal until the attendant was ready to assist the residents. Staff were to feed residents slowly allowing plenty of time between bites. Staff were to provide a relaxing, enjoyable environment during mealtimes. Staff were to encourage the resident to participate with their meal as much as possible. Staff should continue to feed residents until the resident has had enough food or until the meal was finished. There was no mention staff should provide dignity to residents while assisting them with meals. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>39988<br><br>Based on observation, interview, and document review, the facility failed to ensure 1 of 1 carpeted center hall transition space to the center hall wood floor, 1 of 1 center hall wood floor transition space to the north carpeted hall, and 1 of 1 north carpeted hall transition space to resident (R14)'s tile floor was maintained to promote a safe, sanitary, and homelike environment. This had the potential to affect 11 residents that ate in the north dining room and/or lived on the north hall.<br><br>Findings include:<br><br>Observation and interview on 9/23/24 at 2:33 p.m., of R14's entrance to his room identified it was observed to have broken tile with missing pieces and frayed carpet in the doorway of his room with loose strings hanging. R14 who resided in room reported he had never hooked his wheelchair on there yet. He was unsure of any plan to fix the surface of the doorway.<br><br>Observation on 9/24/24 at 8:42 a.m. identified the carpeted center hall connected to the wood floor in hallway in front of north dining room was missing the plastic transition piece leaving an uneven surface and exposing the cement floor beneath. Also observed was the wood floor in center hallway that transitioned to the carpeted north hallway was also missing the plastic transition piece with some fraying of carpet noted.<br><br>Observation and interview on 9/24/24 at 1:46 p.m., with maintenance director reported that staff either verbally report things that need to be fixed or that there was a program work order form that could be filled out. Observation of the areas with the maintenance director revealed he was unaware of the broken and missing tile in doorway of R14's room. He agreed that the carpet leading into doorway of R14's room was frayed with strings hanging and a potential for a staff or resident to get caught on the area and had the potential for injury. He revealed there was an identified issue with keeping the plastic transition pieces in place and he had not figured out how to secure them in order to prevent them from coming loose. The plastic transition pieces the facility used were hard for residents and staff to maneuver over and that was the reason he believed they kept getting ripped off. Observation of the transition area between the north hall and the wood flooring in the center hall and also the wood floor in center hall to the carpet in center hall were missing the plastic transition pieces leaving an uneven surface on the one side and exposed cement with frayed carpet. The maintenance director revealed he was well aware of the issue and had been trying to brainstorm what other types of products he could install for the transition between carpet and wood floor or the tile and felt it was not a struggle for residents and staff to go over.<br><br>Observation and Interview on 9/24/24 at 1:51 p.m., with administrator identified she was aware of the missing plastic pieces between the carpet and tile in the doorways noted above. She was also aware of the missing tile in R14's entry way, however she was unaware of the severity. She agreed R14 had the potential of getting caught on the frayed carpet and becoming injured, and the missing tile was an infection control concern. She further confirmed the uneven surface between the carpeted center hall and the center hall wood floor was a concern as the cement floor was exposed and there was a potential risk for getting caught or tripping. She planned to address the issue immediately.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 9/25/24 at 7:39 a.m., of maintenance director examining the area of the carpeted center hall and transition onto to the center hall wood floor with a outside contractor. The maintenance director reported the facility was able to get a contractor in to look at potential options for repair.<br><br>Review of 8/13/24, Work Order Request policy identified staff were to make request in writing through the online work logbook. All verbal requests would be given low priority and be handled after written request were completed. There were no work order requests submitted for review during the survey related to the above concerns.<br><br>There was no policy related to providing a safe and sanitary environment provided by the end of the survey. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988<br><br>Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect a discharge record for 1 of 12 residents (R37) reviewed for MDS accuracy.<br><br>Findings include:<br><br>The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated ,d+[DATE], identified a purpose to offer clear guidance on how to use (i.e., code) the RAI which was divided in multiple sections. The manual outlined, Section A: Identification Information and within that section under A2105, directed an intent to record the discharge status location. The manual outlined Home/Community, Nursing Home, skilled nursing facility, short-term general hospital, long-term hospital, inpatient rehabilitation facility, inpatient psychiatric facility, intermediate care facility, hospice home, hospice facility, critical access hospital, home under care of organized home health services organization, and deceased , as options.<br><br>R37's [DATE], discharge-return not anticipated MDS identified in section A2105 discharge status marked as resident discharged to a short-term general hospital.<br><br>R37's [DATE], care plan identified she wished to move back home and live in her with spouse, in the meantime R37 may need to transfer to another skilled nursing facility to be closer to home.<br><br>Interview on [DATE] at 2:23 p.m., with registered nurse (RN)-A who identified she was responsible for completing the MDS. She reported R37 discharged to an Assisted Living facility. She revealed she must have miss coded the MDS and checked discharge to the hospital verses assisted living. She reported that she would need to complete a correction on that MDS to identify R37 discharged to an assisted living and re-submit that.<br><br>Interview on [DATE] at 11:11 a.m., with administrator identified she would expect the MDS to be accurate and reflect the status of the resident.<br><br>There was no policy related to accuracy of the MDS provided by the end of survey. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336<br><br>Based on observation, interviews, and document review, the facility failed to ensure that 1 of 1 resident (R29) had hearing aids appropriately replaced when staff failed to remove her hearing aid during bathing, causing it to be damaged by water, and assist R29 with replacement due to staff negligence.<br><br>Findings include:<br><br>R29 had an admitted [DATE].<br><br>Review of R29's 10/25/23, Nurse Admission-Readmission and baseline care plan identified she was hearing impaired and had used bilateral hearing aids.<br><br>Review of R29's 6/15/24, quarterly Minimum Data Set (MDS) identified she had a severe cognitive impairment and had a diagnosis of Post Traumatic Stress Disorder (PTSD), anxiety and depression. Section O under the MDS identified she had hospice services. There was no mention that R29 had impaired hearing and used hearing aids.<br><br>Observation and interview on 9/23/24 at 3:59 p.m., with R29 identified she had worn bilateral hearing aids during her stay at the facility and had purchased the hearing aides for $3,000.00. She was assisted in the shower room (unknown date) by a staff member (unknown), who did not take out her right hearing aid during her shower and had caused it to get wet. R29 voiced concerns she was upset that she could not hear well out of her right ear. R29 picked up a blue and white tin near her bedside table, that stored her left hearing aid and battery. She stated the right was no longer in her possession and she was unsure where the right hearing aid was located.<br><br>Interview on 9/24/24 at 1:52 p.m., with the social services designee identified R29 had informed her that she had a hearing aid missing and was under hospice services but was unsure when R29 had made the initial comment. She stated she had informed the administration and was unsure if administration had addressed R29's concern. She stated she was not aware if an inventory sheet had been completed for R29 upon admission to the facility.<br><br>Interview on 9/25/24 at 1:00 p.m., with director of nursing (DON) stated R29 had a single hearing aid when she was admitted to the facility and was informed by R29's family, R29 does not wear her hearing aids on a routine basis. The facility did not provide a personal inventory sheet during admission for R29 and was not aware of the duration of time that had lapsed when R29 had made the complaint. She informed R29's hospice services of her missing hearing aid and did not have a facility procedure in place for damage of resident hearing devices in place when she was informed of R29's concern. She stated she would put a plan in place to provide education to staff of handing and storing hearing aids for residents. In addition, she stated the facility would pay for R29's hearing aids to be replaced.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/25/24 at 3:20 p.m., with administrator stated her expectations would be for any resident who make a report of missing items to staff to file a grievance on behalf of the resident, so the facility would complete a thorough investigation of the lost items, and if not found the facility the facility would replace the residents' missing items in a timely manner.<br><br>Interview on 9/25/24 at 3:27 p.m., with the activity director identified they were unaware R29 had worn hearing aids.<br><br>Review of 8/2022 Personal Property policy identified the facility representative would advise the resident prior to or upon admission the amount of personal clothing and possession that the resident would keep in his or her room. In addition, complaints of misappropriation or mistreatment of resident property would be promptly investigated.<br><br>There was no policy related to hearing provided by the end of the survey. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>47497<br><br>Based on observation, interview, and document review, the facility failed to obtain and administer ordered pain medication patched (lidocaine) medication for 1 of 6 residents (R189).<br><br>Findings include:<br><br>R189's face sheet identified she was admitted to the facility in September of 2024, with diagnosis of Wernicke's encephalopathy (a disease that affects the brain), chronic pain syndrome, and dementia.<br><br>Observation and interview on 9/25/24 at 8:32 a.m., with the medication aide (TMA)-A, who was preparing R189's medication identified he was unable to locate R189's lidocaine (pain) patches. He looked in the medication cart drawers and checked the medication room. TMA-A identified that R189's lidocaine patches had not been delivered. R189 had not received her lidocaine patches for the past 9 days.<br><br>R189's administration record identified staff were to apply 4 lidocaine 4% external patches daily at 8:00 a.m., for chronic pain syndrome. The administration record documentation reflected there were no patches available on 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24. R189's administration record pain assessments for the previously mentioned dates revealed no pattern of increased pain.<br><br>Interview on 9/25/24, at 10:00 a.m., with licensed practical nurse (LPN)-A identified she was not aware that R189 had no supply of lidocaine patches. If the medication is not available the medication aide should notify the nurse, if the medication is not available in the emergency medication kit, the nurse would call the pharmacy to see when it would be delivered. If the medication could be delivered or if the resident was going to miss a dose, she would notify the resident doctor. LPN-A identified she had not been notified that R189 had no supply of her lidocaine patches, and she was unable to locate any documentation to indicate anyone at the facility had followed up with the pharmacy, notified a physician, or completed an incident report of the 9 missed doses.<br><br>Interview on 9/25/24 at 1:07 p.m., with the director of nursing (DON) identified that she agreed with the above findings. She would have expected the nurse to follow up with the pharmacy to see if the medication could be delivered at the time of the first missed dose. If the medication could not be delivered causing the resident to miss a dose, she would expect the nurse to notify the physician for guidance and complete an incident report.<br><br>A facility policy was requested; however, nothing was provided by the end of the survey. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336<br><br>Based on interview and document review, the facility failed to act upon pharmacy recommendations to modify administration times and limit potential interaction and/or side effects for medication administered to 1 of 3 residents (R34).<br><br>Findings include:<br><br>Review of R34's 9/07/24, Significant change Minimum Data Set (MDS) identified she had a diagnosis of schizoaffective disorder, anxiety, chronic kidney disease, thyroid disorder and had a moderate cognitive impairment.<br><br>Review of R34's 6/11/24, Consultant Pharmacist Medication Regimen Review, identified the pharmacist noted Fibercon and calcium carbonate medication may interact with levothyroxine (thyroid) medication. It is recommended that the medications be separated by 4 hours and had been administered between 7:30 a.m. and 8:00 a.m. Consider moving Fibercon to later in the day, also consider giving calcium at noon, supper, and bedtime to avoid interactions with the levothyroxine. There was no mention of how the calcium carbonate medication was to be adjusted.<br><br>Review of R34's, Order Summary report identified she had taken Oyster shell calcium + D (calcium carbonate) 500-5 milligram (mg)- microgram (mcg) and was to take 1 tablet three times a day for supplement use and Levothyroxine 150 mcg give 1 tablet in the morning for hypothyroidism (low thyroid levels), both with a start date of 5/17/24.<br><br>Review of R34's, 6/01/24 to 6/30/24 Medication Administration Record (MAR) identified R34 had taken 30 doses of calcium carbonate at 8:00 a.m.<br><br>Review of R34's, 7/01/24 to 7/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m.<br><br>Review of R34's, 8/01/24 to 8/31/24 MAR identified R34 had taken 31 doses of calcium carbonate at 8:00 a.m.<br><br>Review of R34's, 9/01/24 to 9/31/24 [DATE] doses of calcium carbonate at 8:00 a.m.<br><br>Interview on 9/25/24 at 11:11 a.m., with the clinical pharmacist stated her recommendation for both calcium carbonate and levothyroxine medication would cause potential interaction if continued long term.<br><br>Interview on 9/25/4 at 12:55 p.m., with director of nursing stated staff should have clarified the pharmacy recommendation and make necessary changes under the direction of the clinical pharmacist.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of 5/14/24 Gradual Dose Reduction of Psychotropic Drugs policy identified pharmacy medication reviews occurred monthly, in addition, medication modification opportunities would depend on factors, including the coexistence of medications, individual risk factors and pharmacological characteristics of those medications. Lastly, medication consideration to continue, discontinue or modify medications was an acceptable standard of practice to minimize or prevent adverse consequences related to medication interactions. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336<br><br>Based on interview and document review, the facility failed to ensure 2 of 5 residents (R24 and R33) were offered pneumococcal PCV-15 or PCV-20 vaccination or declination form, per Centers for Disease Control (CDC) recommendations, reviewed for vaccinations.<br><br>Findings include:<br><br>R24's, 8/14/24 Significant Change Minimum Data Assessment (MDS) identified R24 was [AGE] years old was admitted [DATE]. R24's MDS under Section O- Special Treatments and Programs indicated R24's pneumococcal vaccinations were up to date. R24's vaccination record identified he received PCV-13 on 12/21/15 followed by the PPSV-23 on 12/20/18. There was no documentation to support R24 had been offered or declined the PCV-15 or PCV-20 to ensure he was up to date with the current CDC guidelines.<br><br>R33's, 7/26/24 Significant Change MDS identified R33 was [AGE] years old and was admitted [DATE]. R33's MDS under Section O- Special Treatments and Programs indicated R33's pneumococcal vaccinations were not up to date. However, the record lacked evidence R33 had received the PCV vaccines despite the consent for it being obtained May 2024.<br><br>Interview on 9/26/24 at 11:26 a.m., with director of nursing stated the facility would plan to offer the vaccine for residents.<br><br>Review of 4/08/24 Pneumococcal Vaccine policy identified the facility would determine eligibility of residents PCV status and would offer the vaccine within 30 days of admission, unless medically contraindicated or the resident was previously vaccinated and would receive information and education of the benefits and potential side effects of the vaccine. Lastly, the facility would administer vaccines or re-vaccinate in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. |