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	07/10/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to update code status for 1 of 16 resident (R40) who requested to have his code status changed.Findings include:Document review on [DATE] at 4:51 p.m., R40 was identified to be a full code (Cardiopulmonary Resuscitation (CPR)) noted on his electronic medical record dashboard. Review of R40's Provider Orders for Life-Sustaining Treatment (POLST) signed by the resident and the physician identified he had changed his code status on [DATE] from CPR to Do not resuscitate (DNR).Interview on [DATE], at 2:00 p.m., with licensed practical nurse (LPN)-A identified if a resident's heart stops, they look at the dashboard to check code status, she explained the dashboard is at the top of a resident's main page in Point Click Care (PCC). PCC is the electronic system the facility uses for resident medical records. LPN-A opened R40's PCC main page and identified his code status is CPR. She identified when a resident is admitted they complete a Provider Orders for Life-Sustaining Treatment (POLST) form. A registered nurse updates the residents EMR in PCC and has the POLST reviewed and signed by the physician. LPN-A clicked a button next to the code status on the dashboard next to the code status to pull up R40's POLST. R40's most recent POLST identified he had requested to be DNR. LPN-A confirmed his code status listed on the dashboard in PCC was incorrect. Interview on [DATE] at 2:15 p.m., with the director of nursing identified if someone codes (heart stops beating) staff were to check the dashboard in PCC to check code status. Staff also have access to the POLST through the dashboard. She agreed R40's code status on the PCC dashboard was incorrect. At his last appointment, R40 requested to have his code status changed from CPR to DNR because he was considering hospice. Nursing should have put the new order in, but it must have been missed. She identified she does audits on code status a couple times a year and the last one completed was about 2 days prior to R40's change. Review of the facility provided undated Residents' Rights Regarding Treatment and Advance Directives policy identified the facility would determine code status upon admission. Advance directive documents provided to the facility would be placed in the medical record. During the care planning process, the facility would identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. The policy made no mention how staff were to confirm code status should a resident require CPR if elected while living at the facility.

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and document review, the facility failed to have licensed nursing coverage on staff for 24 hours a day, based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility. Findings include: Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing [NAME] Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days per week, for 6 of 90 days reviewed. This had the potential to affect all 39 residents living in the facility.Findings include: Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on:1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25.2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25.3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of March 2025 Nursing Services-Registered Nurse (RN) policy identified the facility was to utilize the services of an RN 8 consecutive hours per day, 7 days per week. The director of nursing (DON) may service as a charge nurse when the facility had a daily occupancy of 60 or fewer residents. In addition, the facility, was to submit timely and accurate staffing data through CMS payroll-based Journal (PBJ) system.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and document review, the facility failed to ensure infection control practices were maintained to ensure dietary staff were wearing a hair net and/or beard nets while in 1 of 1 kitchen and during meal services. The facility also failed to ensure 1 of 2 dining room refrigerators remained clean, and food was dated within the refrigerator to ensure it was not used beyond expiration. Additionally, the facility failed to ensure all Chlorine test strips for monitoring the dishwasher chemical level were not expired. Findings include:Observation and interview on 7/7/25 at 11:32 a.m., identified upon entrance to the kitchen for initial tour, dietary aide (DA)-A was preparing drinks for transportation to the dining rooms for the noon meal. DA-A had no hair net on. DA-A reported she was supposed to be wearing a hair net and there was no reason she did not have it on. Observation and interview on 7/7/25 at 11:40 a.m., cook (C)-A was standing behind the steam table outside of the north dining room and dishing up food for residents' noon meal. C-A had a hair net on but no beard net on. C-A had a mustache and beard. C-A reported he had never worn a beard net before; he was unaware he needed to wear one and was not even sure if the facility had any. Observation on 7/7/25 at 12:07 p.m., of the refrigerator in the central dining room which contained 2 large metal bins of individually wrapped 1/2 sandwiches that were undated. There was something pink spilled all over the bottom of the refrigerator and on the inside door of the refrigerator. The floor directly in front of the refrigerator was extremely sticky and dark brown/black in color. Observation on 7/7/25 at 5:24 p.m., C-A was standing behind the steam table in the central dining room dishing up food for the resident evening meal. C-A had a hair net on and no beard net on. Observation on 7/8/25 at 9:40 C-A just finished serving breakfast and had no beard net on. Observation and interview on 7/8/25 at 10:00 a.m., of the dishwasher cycle and DA-A testing the dishwasher chemical level with Hydrion Chlorine Test strips identified that the test strips had expired on 6/1/25. DA-A was unaware the test strips had expired and discarded the testing strips and obtained a new packet. Observation on 7/9/25 at 8:36 a.m., of the refrigerator in the central dining room with DA-A and maintenance director who confirmed pink juice had been spilled all over the bottom of the refrigerator and the inside part of the refrigerator door. The floor area just in front of the refrigerator was dirty with dark brown/black sticky substance on the floor. C-A reported she believed that housekeeping was responsible for cleaning the refrigerator and floor. The maintenance director agreed that the floor was very sticky, and the refrigerator was dirty and needed to be cleaned. Observation and interview on 7/9/25 at 8:45 a.m. with dietary manager assistant (DMA)-A removed items from the bottom shelf of the refrigerator in the central dining room and agreed that the refrigerator was dirty with some sort of juice spilled all over the bottom of the refrigerator and the inside door of the refrigerator. She reported that it was dietary responsibility to clean the inside of the refrigerator and housekeeping responsibility to clean the outside and the floors in the dining room. She further confirmed that all dietary staff should be wearing hair nets and beard net if needed in the kitchen and when serving food. If there are no beard nets available staff can use a hair net to cover their beard. Staff should be checking the expiration date on the chemical test strips prior to checking the chemical level in the dishwasher. Interview on 7/9/25 at 9:02 a.m., with dietician identified all food in the refrigerators should be dated. The dietary staff should be monitoring the refrigerators for expired foods and cleaning on a regular basis. Her expectation was that staff would be wearing hair net and/or beard nets when in the kitchen and during food service. The chemical strips should be monitored for expiration and new ones ordered when needed. Review of undated, Dietary Employee Personal Hygiene policy identified all dietary staff must wear hair restraints including beard restraints to prevent hair from contacting food. Review of undated, Routine Cleaning and Disinfection policy identified routine cleaning, and disinfection was maintained to ensure safe, sanitary environment and to prevent transmission or development of infections to the extent possible. Cleaning of visible soil from objects and surfaced and frequently touched surfaces would be performed. Review of undated, Low Temperature Dish Machine Guidelines identified the wash and rinse cycle should be maintained between 120-145 Fahrenheit. The low temperature sanitizer level should be checked daily with the Chlorine test strip with an acceptable range from 50-100 ppm.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to implement 1 of 1 facility assessment and ensure the required nursing staff were scheduled and working to provide care and services to residents. Findings include: Review of the 2/09/25, Daily Assignment Sheet identified 1 charge nurse was assigned for the day and 1 charge nurse for the evening shift (minimum 12 hr. shifts). Licensed practical nurse (LPN)-E was listed as having worked the day shift. Registered nurse (RN)-C was listed as having worked the night shift. Review of 2/09/25, Individual Daily Staffing [NAME] Report 1702D identified the facility data submitted for Provider Based Journal (PBJ) noted of the floor staff working that day, there was noted to be 1 registered nurse (RN-C), and 1 contract LPN (LPN-E) captured for hours worked. Review of 2/09/25, staff timesheet punches provided by the facility identified only RN-C was clocked in as having worked. There was no way to verify LPN-E had worked the hours documented on the assignment sheet and as captured in the PBJ. Review of the facility schedule and timesheets for January 2025, February 2025, and March 2025 identified on:1) January, there was no RN coverage for 2 of 31 days: 1/24/25 and 1/31/25.2) February, there was no RN coverage for 3 of 28 days: 2/09/25, 2/14/25, 2/15/25.3) March, there was no RN coverage for 1 of 31 days: 3/02/25. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. The DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of April 2025, facility assessment staffing plan portion identified it was based on the facility and community risk assessments, in addition to patient per day (PPD) methodology to determine the maximum number of hour available per day. Staffing assignments and variances was managed by moving staff, calling staff off, or calling in relief or extra staff, after staffing requirements was completed. Direct care staffing hours identified to be required were: 1 RN or LPN per day shift and 1 RN or LPN per evening/night shift. A copy of contract staff timesheets was requested but not received.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Based on interview and document review, the facility failed to submit accurate staffing data based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed - Quarter 2, 2025, (January 1 to March 31st), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 39 residents living in the facility.Findings include: JANUARYReview of the 1/24/25, Daily Assignment Sheet identified 1 charge nurse as noted to be on the day shift, 1 charge nurse on the evening shift, and 1 nurse for RN coverage. Review of 1/24/25, staff timesheets identified:1) Licensed practical nurse (LPN)-B had worked 06:59 a.m. to 11:36 a.m. and 11:59 a.m. to 9:06 p.m., for a total of 13.62 hours.2) LPN-C had worked 06:00 a.m. to 7:40 p.m., for a total of 12.67 hours.3) RN-C had worked 06:03 p.m. to 06:30 a.m., the next day for a total of 11.45 hours. Review of the 1/24/25, Individual Daily Staffing- 1702D [NAME] Report identified 1 LPN with 13.62 captured hours, and 1RN with 13.0 captured hours. FEBRUARYReview of the 2/21/25, Daily Assignment Sheet identified 1 charge nurse on the day shift and 1 nurse for RN coverage. The sheet lacked evidence a charge nurse was assigned on the evening shift. Review of 2/21/25, staff time sheets identified: 1) The director of nursing (DON) had worked 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-B had worked from 8:09 a.m. to 12:42 a.m., the next day for a total of 16.05 hours. 3) RN-C had worked from 6:05 p.m., to 7:33 a.m., the next day for a total of 12. 97 hours. Review of the 2/21/25, Individual Daily Staffing- 1702D [NAME] Report identified only 1 LPN with 14.23 captured hours, the director of nursing for 8 hours, and 1 registered nurse with 12.35 captured hours. Review of the 2/28/25, Daily Assignment Sheet identified 1 RN was assigned to the day shift (RN-B) who was the Minimum Data Set (MDS nurse) and 1 RN was assigned to the evening/night shift. Review of 2/28/25, staff time sheets identified:1) The DON had worked 08:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 2) RN-C had worked 08:08 a.m. to 7:43 p.m., for a total of 11.08 hours.3) LPN-B had worked from 6:13 a.m. to 11:53 a.m. and again from 11:53 a.m. to 7:58 p.m., for a total of 13.23 hours captured.4) LPN-D had worked 5:59 p.m. to 06:57 a.m., for a total of 12.47 hours. Review of 2/28/25, Individual Daily Staffing- 1702D [NAME] Report identified 1 RN with administrative duties only worked for 11.08 hours. No other floor RN staff were noted. 3 LPN's were submitted. 1 LPN with 13.23 hours, 1 LPN with 12.43, and 1 contracted LPN with 14.38 hours. The DON had 8 hours captured. MARCH Review of the 3/21/25, Facility Daily assignment sheet identified 1 LPN (LPN-E) worked the day shift, and also on days was RN-B (the MDS nurse), who was assigned as RN coverage. There was no nurse listed for the evening/night shift. Review of 3/21/25, staff timesheets identified: 1) LPN-B had worked from 7:59 a.m. to 09:55 a.m. and again from 10:38 a.m. to 7:16 p.m., for a total of 10.57 hours. 2) The DON had worked from 8:00 a.m. to 5:00 p.m., for a total of 8.50 hours. 3) RN-B classified as RN with administrative duties, worked from 8:53 a.m. to 12:16 p.m., for a total of 3.38 hours.4) RN-C had worked 7:13 p.m. to 06:29 a.m., for a total of 10.77 hours. Review of 3/21/25, 1702D [NAME] report identified 1 RN with administrative duties worked 3.38 hours, the DON hours captured were 8.0, 1 RN hours were captured as 10.85, and 2 LPN's (1 contract and 1 exempt) were captured with 10. 57 and 13.72 hours respectively. There was no additional RN with any captured hours submitted. There was no indication the above-mentioned data submitted had been checked for accuracy prior to their respective submissions. Interview on 7/10/25 at 9:53 a.m., with director of nursing (DON) identified the facility had revised staffing hours according to resident care needs and reviewed PBJ hours weekly before submission. Nursing staff hours was reviewed and discussed every day at their interdisciplinary team (IDT) meetings and communicated with the administrator. DON would expect nursing schedules to be reviewed daily, identify gaps of nursing coverage, and communicate those concerns effectively to reduce inadequate staffing on the units. Interview on 7/10/25 at 9:58 a.m., with administrator identified the facility's new administration team implemented tracking of RN coverage and nursing staff shortage on the units. The facility currently overstaffs their employees on the units above the required allotted hours needed daily to ensure services and care needs for the resident population. Review of the July 2024, Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Frequently Asked Questions, located at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/pbj-policy-manual-faq-11-19-2018.pdf, identified reporting shall be based on the employee's primary role. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out when needed). Facilities shall still report just the total hours of that employee based on their primary role. However, CMS recognizes that staff may completely shift their primary role in a given day. For example, a nurse who spends

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interview the facility failed to disinfect 1of 2 glucometers (capillary blood glucose sampling device) after use to prevent transmission of blood borne diseases. Additionally, the facility failed to complete accurate staff illness surveillance for 2 of 2 staff. Findings include: Observation on 7/9/25 at 7:43 a.m., with registered nurse (RN)-A identified RN-A gathered the glucometer from the treatment cart to check R15’s blood sugar. RN-A used a lancet to prick R15’s finger to obtain a blood sample to test R15’s blood sugar with the glucometer. RN-A exited R15’s room and walked back to the treatment cart where she placed the used lancet in the sharp’s container and the glucometer back in the drawer next to another resident’s glucometer without first disinfecting it. She walked back to the nurse’s station to chart the blood sugar and check to see if R15 required any sliding scale insulin. Interview on 7/9/25 at 7:55 a.m., RN-A stated she had meant to disinfect the glucometer, but she had gotten “nervous and forgot”. RN-A then opened the treatment cart and pulled both glucometers out of the drawer. She used purple top Sani-cloth disinfecting wipes and briefly wiped off both glucometers and then returned the glucometers to the drawer. RN-A did not allow any “wet” contact time per the Sani-cloth instructions prior to returning glucometers to the treatment cart drawer. The General Guidelines for Use undated, (purple top) Super Sani-cloth germicidal disposable wipes instructions identified: 1) to unfold the wipe and thoroughly wet the surface 2) allow treated surface to remain wet for two minutes. Let air dry. 3) Do not reuse towelette. Dispose of used towelette in trash. Interview on 7/9/25 at 9:37 a.m., with director of nursing (DON) identified the glucometer should be cleaned after each use with an alcohol wipe for 60 seconds and thought the purple top sanitizer was to remain wet for 3 minutes. She was unsure of the exact time and stated she would check on that. She would expect the glucometer would be disinfected after each use, prior to placing in the co-mingled medication cart. She identified there was a high potential for cross contamination without appropriate disinfection having been performed. Review of the undated, Glucometer Disinfection policy identified cleaning was the removal of visible soil from the objects and surfaces and disinfection was the process that eliminate many or all pathogenic microorganisms, except bacterial spores on objects. Staff were to clean and disinfect glucometers after each use. Staff were to obtain 2 disinfectant wipes and clean the surface of the glucometer with the first wipe and then use the second wipe to disinfect the glucometer thoroughly and allow to air dry. EMPLOYEE SURVEILLANCE Review of the facilities staff illness logs from 2/21/25 through 6/30/25 noted the following categories: Department, First/Last name, absent date, type, reason, number of unexcused absences, illness testing/type, results, and number of days off. The illness logs identified the following: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1.) Activity Aid (AA)-A called off sick on 4/16/25, with influenza. The staff illness log did not identify what day AA-A returned to work, how they were cleared to return, or how many days she was out. 2.) Nursing assistant (NA)-A called off sick on 6/23/25, the type of call in was “personal”, and the reason was “unknown”. The log did not identify a return-to-work date, how they were cleared to return to work, or number of days off. Interview on 7/7/25 at 3:40 p.m., with the facilities infection preventionist identified she keeps a staff illness log for surveillance and in addition they use a form called Staff Call-In/Illness Report. The form is filled out by the charge nurse when a staff calls off. Review of the facility staff call in/illness reports identified the following: 1.) AA-A called off on 4/16/25, the reason for her absence was influenza, the report did not identify a return-to-work date, how they were cleared to return to work, or number of days absent. 2.) (NA)-A called off on 6/23/25 at 4:00 a.m., the reason was “feeling sick”. The report did not indicate symptoms, how they were cleared to return to work, or a return-to-work date. Interview on 7/9/25 at 10:46 a.m., with the director of nursing identified she agreed with the above finding. The facility has had a major turn over in staff and they are working on improving their staff surveillance program. She was unable to provide documentation of any additional training she had completed with the infection preventionist or other staff regarding staff surveillance. Review of the facilities undated Infection Surveillance policy identified the facility would collect data to properly identify possible communicable diseases or infections among residents and staff before the spread by identifying infections, signs and symptoms, location, number of residents or staff who developed infections, observation of staff, trends, and patterns. The policy made no mention that staff would document the return-to-work date in the staff illness surveillance.