



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 29, 2026

Administrator
Meeker Manor Rehabilitation Center, LLC
600 SOUTH DAVIS AVENUE
LITCHFIELD, MN 55355

RE: CCN:245361

Cycle Start Date: May 20, 2026

Dear Administrator:

On May 20, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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May 29, 2026

Administrator
Meeker Manor Rehabilitation Center, LLC
600 SOUTH DAVIS AVENUE
LITCHFIELD, MN 55355

Re: State Nursing Home Licensing Orders
Event ID: 22E044-H1

Dear Administrator:

The above facility survey was completed on May 20, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software.

Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 5/17/26 to 5/20/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/03/2026
F0000	INITIAL COMMENTS On 5/17/26 to 5/20/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H53615584C (iQIES #2637674) H53612481C (iQIES #2641617) H53612482C (iQIES #2657820) H53612480C (iQIES #2744687 AND #2795174) H53612477C (iQIES #3005186) H53612493C (iQIES #2792831) H53612478C (iQIES #2992272) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification	F0000		06/03/2026

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 reverse for further 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
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F0000	Continued from page 1 of compliance.	F0000		06/03/2026
F0554 SS = D	<p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.</p> <p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure an interdisciplinary team (IDT) assessment was completed to determine whether self-administration of medication was clinically appropriate and safe prior to permitting self-administration of nebulizer treatments, for 1 of 1 resident (R1) reviewed for self-administration of medications.</p> <p>Findings include:</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 3/30/26, identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).</p> <p>R1's signed physician orders dated 4/29/26, identified an order for Ipratropium-Albuterol 0.5-2.5 mg/3 mL (milliliters) nebulizer treatments administered three times daily, initiated on 3/25/26.</p> <p>R1's electronic medical record (EMR) identified a physician order initiated on 5/18/26, indicated R1 was permitted to self-administer nebulizer treatments following staff setup. The EMR lacked evidence an interdisciplinary team (IDT) self-administration assessment had been completed</p>	F0554	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>F0554 SS=D</p> <p>The process for satisfying this requirement has been reviewed and revised as needed, to ensure that self-administration of medication is clinically appropriate and safe prior to permitting self-administration of nebulizer treatments.</p> <p>R1 has been assessed for self-administration of nebulizer treatments, resident is able to independently self-administer nebulizer treatment following setup.</p> <p>All other residents with provider ordered nebulizer treatments have the potential to be affected.</p> <p>All like residents have been assessed for self-administration of nebulizer treatments, adjustments were made accordingly.</p>	06/10/2026

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F0554 SS = D	<p>Continued from page 2 prior to implementation of the order to determine whether self-administration of the nebulizer was clinically appropriate and safe.</p> <p>Further R1's EMR lacked evidence an assessment had been completed to determine R1's competency and safety to self-administer the nebulizer medication and treatment. The EMR further failed to identify documentation addressing R1's ability to understand the medication purpose, follow treatment directions, safely operate nebulizer equipment, recognize side effects or adverse reactions, or ensure safe administration and storage of the medication and equipment.</p> <p>During observation on 5/17/26 at 1:27 p.m. R1 was observed with nebulizer equipment and medication available in the resident room.</p> <p>During interview on 5/19/26 at 11:57 a.m. R1 stated nursing staff set up the medication cup for the nebulizer treatment and then left the room while the treatment was running. R1 stated staff later returned to ensure the machine was turned off. Staff cleaned the nebulizer mask after the treatment was completed.</p> <p>During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated she set up the nebulizer treatment and later returned to ensure the machine was no longer running. LPN-A further stated the nebulizer mask was cleaned and placed on a paper towel to air dry.</p> <p>During interview on 5/20/26 at 9:57 a.m. registered nurse (RN)-A stated a self-administration assessment was completed for residents who wished to self-administer medications and then submitted to the provider for review and an order. RN-A confirmed a self-administration assessment had not been completed for R1 and stated the assessment should have been completed to ensure R1 could safely and appropriately self-administer the medication.</p> <p>During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated residents wishing to self-administer medications should have had a full assessment completed to evaluate their ability and competency. The DON stated staff were expected to contact the provider for an order and confirmed the self-administration assessment should have been completed prior to a resident being permitted to self-administer medications.</p> <p>Review of the facility policy titled Self-Administration</p>	F0554	<p>Continued from page 2</p> <p>All necessary Meeker Manor nursing staff received education regarding self-administration of medications utilizing Monarch Healthcare Management Self-Administration of Medications policy.</p> <p>Compliance audits will be completed one time per week for four weeks, one time every two weeks for four weeks, and one time per month for one month. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI</p> <p>Director of Nursing or designee is responsible party</p> <p>Compliance will be achieved on or before 6/10/2026.</p>	06/10/2026

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F0554 SS = D	Continued from page 3 of Medications, revised 2/2024, identified residents could self-administer medications only after the interdisciplinary team (IDT) determined the practice was clinically appropriate and safe. The policy indicated the IDT was responsible for assessing residents' cognitive and physical abilities and evaluating factors including the resident's ability to understand medication labels and instructions, comprehend the medication's purpose and potential side effects, safely administer medications, and safely store medications. The policy further indicated approval for self-administration was to be documented in the medical record and care plan, periodically reassessed based on changes in condition, and residents determined unable to safely self-administer medications were to receive medication administration from nursing staff.	F0554		06/10/2026
F0605 SS = D	<p>Right to be Free from Chemical Restraints</p> <p>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)</p> <p>§483.10(e) Respect and Dignity.</p> <p>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any . . . chemical restraints</p> <p>imposed for purposes of discipline or convenience, and not required to treat the</p> <p>resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of</p> <p>resident property, and exploitation as defined in this subpart. This includes but is</p> <p>not limited to freedom from corporal punishment, involuntary seclusion and any</p> <p>physical or chemical restraint not required to treat the resident's medical</p> <p>symptoms.</p> <p>§483.12(a) The facility must- . . .</p>	F0605	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>F0605 SS=D</p> <p>The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents receiving psychotropic medications were adequately assessed and monitored. As well as initiating target behavior monitoring for unnecessary psychotropic medications.</p> <p>R3's AIMS assessment has been completed and target behavior monitoring has been initiated.</p>	06/10/2026

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F0605 SS = D	Continued from page 4 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F0605	Continued from page 4 All other residents with provider ordered antipsychotic medications have the potential to be affected. All like residents have been reviewed for AIMS assessment completion and target behavior monitoring, adjustments were made accordingly. All necessary Meeker Manor nursing staff received education regarding Monarch Healthcare Management Psychotropic Medication Use policy. Compliance audits will be completed one time per week for four weeks, one time every two weeks for four weeks, and one time per month for one month. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI Director of Nursing or designee is responsible party Compliance will be achieved on or before 6/10/2026.	06/10/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 05/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355</p>		
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<p>F0605 SS = D</p>	<p>Continued from page 5</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure residents receiving psychotropic medications were adequately assessed and monitored. Further the facility failed to initiate target behavior monitoring for 1 of 5 residents (R3) reviewed for unnecessary psychotropic medications.</p> <p>Findings include:</p> <p>R3's admission Minimum Data Set (MDS) dated 4/20/26, identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking abilities), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (a condition involving excessive worry or fear), and mood affective disorder (a mental health condition affecting mood and emotional state). The MDS further identified R3 received antipsychotic, antidepressant, anticonvulsant, and anticoagulant</p>	<p>F0605</p>		<p>06/10/2026</p>

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F0605 SS = D	<p>Continued from page 6 medications.</p> <p>R3's signed physician orders dated 4/29/26, identified an order dated 04/14/2026 at 12:30 p.m. for Risperidone 0.25 mg (milligram), two tablets by mouth every four hours as needed (PRN) for agitation and paranoia, with a maximum of three PRN doses in 24 hours. Review further identified an order dated 4/14/26 at 2:00 p.m. for Risperidone 0.5 mg, one tablet by mouth three times a day for paranoia/agitation.</p> <p>R3's electronic medical record (EMR) on 5/18/26, failed to identify documentation an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed upon admission despite R3 being admitted on 4/14/26 and received antipsychotic medications.</p> <p>R3's EMR lacked evidence target behavior monitoring had been initiated for the antipsychotic medications. The EMR failed to identify measurable target behaviors, including documentation of frequency, duration, severity, precipitating factors, or response to interventions for R3's agitation and paranoia. The facility was unable to demonstrate ongoing monitoring of the effectiveness of Risperidone therapy or the continued need for the medications.</p> <p>R3's EMR further identified an AIMS assessment was completed on 5/18/26 after surveyor request; however, the assessment was not completed upon admission or initiated timely in relation to the start of R3's antipsychotic medications on 4/14/26. The delayed completion did not ensure timely monitoring for potential adverse effects associated with antipsychotic medication use.</p> <p>During interview on 5/20/26 at 9:57 a.m., registered nurse case manager (RN)-A stated residents receiving antipsychotic medications required an AIMS assessment completed, orthostatic blood pressures obtained as ordered, target behavior monitoring initiated, and side effects monitored. RN-A reviewed R3's EMR and stated she had completed the AIMS assessment "the other day." RN-A stated the AIMS assessment should have been completed within the first week of admission because it was important to establish the resident's baseline status prior to ongoing antipsychotic use. RN-A further confirmed behavior and side effect monitoring had not been initiated until recently and should have been implemented earlier. RN-A stated monitoring was important, particularly because the facility utilized agency staff, so all staff would be</p>	F0605		06/10/2026

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F0605 SS = D	Continued from page 7 aware of the resident's behaviors, response to medication, and ongoing needs. During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated residents receiving antipsychotic medications required ongoing monitoring to identify changes in condition and determine effectiveness of the medication regimen. The DON stated behavioral monitoring and an AIMS assessment were completed upon admission or initiation of antipsychotic medications. The DON reviewed R3's EMR and confirmed the AIMS assessment was completed on 5/18/26; however, it should have been completed upon admission. The DON further confirmed target behavior monitoring should have been in place for R3 and acknowledged monitoring had not been initiated. The DON stated target behavior monitoring was important to ensure staff understood what behaviors were occurring and to evaluate whether the medications were effective. Review of the facility policy titled Psychotropic Medication Use Policy, revised 5/2025, identified psychotropic medications were to be used only when clinically indicated and supported by documented target symptoms and behavioral monitoring. The policy further identified residents receiving antipsychotic medications would receive ongoing monitoring for effectiveness and adverse consequences, including documentation of identified target behaviors and individualized interventions. The policy required target behaviors to be monitored and supported in the clinical record. In addition, the policy identified residents initiated on antipsychotic medications would receive DISCUS or AIMS assessments at baseline, with ongoing monitoring completed thereafter. The policy further identified monitoring for behavioral symptoms and re-evaluation of residents receiving new psychotropic medications or dose changes to assess medication effectiveness and continued need.	F0605		06/10/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care	F0656	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	06/10/2026

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<p>F0656 SS = D</p>	<p>Continued from page 8 plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to develop and implement comprehensive, person-centered care plans to address significant medical conditions and medication-related risks, including failure to care plan anticoagulant therapy for 2 of 2 residents (R1 and R3) reviewed for anticoagulant medications, and failure to care plan cardiac conditions, pacemaker presence, and condom catheter use for 1 of 2 residents (R1) reviewed for cardiac care needs.</p> <p>Findings include:</p>	<p>F0656</p>	<p>Continued from page 8 Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>F0656 SS=D</p> <p>The process for satisfying this requirement has been reviewed and revised as needed, to ensure that the development and implementation of comprehensive person-centered care planning addresses medical conditions and medication-related risks.</p> <p>R1's care plan has been reviewed and revised to include anticoagulant medication, pacemaker presence, cardiac conditions and condom catheter use.</p> <p>R3's care plan has been reviewed and revised to include anticoagulant medication, pacemaker presence, and cardiac conditions.</p> <p>All other residents with anticoagulant medication, pacemaker presence, cardiac conditions, and condom catheter use have the potential to be affected.</p> <p>All like residents' care plans have been reviewed and revised, adjustments were made accordingly.</p> <p>All necessary Meeker Manor nursing staff received education utilizing Monarch Healthcare Management Care Planning policy.</p> <p>Compliance audits will be completed one time per week for four weeks, one time every two weeks for four weeks, and one time per month for one month. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI</p> <p>Director of Nursing or designee is responsible party</p>	<p>06/10/2026</p>

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F0656 SS = D	<p>Continued from page 9</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 3/30/26, identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), depression (a mood disorder causing persistent sadness or loss of interest), and presence of a cardiac pacemaker (an implanted device used to regulate heart rhythm). The MDS further identified R1 received anticoagulant medications.</p> <p>R1's signed physician orders dated 4/29/26, indicated Eliquis (apixaban) anticoagulant medication dated 3/12/26, and an order to apply a condom catheter at bedtime (HS) and remove when getting up for the day dated 3/15/26.</p> <p>R1's comprehensive care plan printed 5/20/26, failed to identify interventions or monitoring related to anticoagulant medication use, including bleeding risk, monitoring for adverse effects, or staff awareness of anticoagulant precautions. Further, care plan lacked evidence of interventions related to R1's cardiac conditions, presence of a pacemaker, or use of a condom catheter, including monitoring for skin integrity or resident-specific catheter care preferences.</p> <p>R3's admission Minimum Data Set (MDS) dated 4/20/26, identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking abilities), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (a condition involving excessive worry or fear), and mood affective disorder (a mental health condition affecting mood and emotional state). The MDS further identified R3 received anticoagulant medications.</p> <p>R3's signed physician orders dated 5/4/26, indicated an order for Eliquis (apixaban) anticoagulant medication.</p>	F0656	<p>Continued from page 9</p> <p>Compliance will be achieved on or before 6/10/2026.</p>	06/10/2026

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F0656 SS = D	<p>Continued from page 10</p> <p>R3's comprehensive care plan printed 5/19/26, lacked evidence of anticoagulant therapy, bleeding risk precautions, monitoring for adverse effects, or interventions related to anticoagulant medication use.</p> <p>During interview on 5/20/26 at 9:57 a.m. registered nurse case manager (RN)-A stated the care plan was a "community effort" involving the MDS coordinator, director of nursing (DON), herself, and the other case manager. RN-A stated R1's condom catheter should have been referenced on the care plan to address monitoring for skin integrity and the resident's preferred care needs. RN-A reviewed R1's care plan and confirmed the resident had a pacemaker, and that cardiac conditions had not been addressed on the care plan and should have been. RN-A further confirmed R1's anticoagulant medication had not been addressed on the care plan and should have been. RN-A stated it was important for significant diagnoses, devices, and medications to be care planned, especially because the facility utilized agency staff, so all staff were aware of the resident's care needs. RN-A also reviewed R3's care plan and confirmed anticoagulant therapy had not been addressed and should have been included in the care plan.</p> <p>During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated R1's condom catheter should have been addressed on the care plan for monitoring of output, skin integrity, and signs and symptoms of irritation or infection. The DON stated regular skin checks should have been completed, and drainage bags were expected to be changed weekly, which would have been documented on the treatment administration record (TAR). The DON stated the catheter was disposable and the care plan was important so staff were aware of the residents' needs and it guided resident care. The DON further stated R1's cardiac conditions and presence of a pacemaker should have been addressed on the care plan so staff were aware of the resident's cardiac history, monitoring needs, and potential complications. The DON stated anticoagulant medications should also have been included in the care plan so staff could monitor for changes and be aware of the residents' conditions and risks associated with anticoagulant use. The DON confirmed anticoagulant therapy had not been addressed on R1's or R3's care plans and should have been included.</p> <p>The facility's policy titled "Comprehensive Care Plans," revised 1/25, identified the facility would develop and maintain individualized,</p>	F0656		06/10/2026

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F0656 SS = D	Continued from page 11 person-centered care plans that addressed each resident's diagnoses, medical conditions, physician orders, treatments, devices, medications, and identified risks. The policy further identified care plans were intended to guide staff in the delivery of care, ensure continuity of care between caregivers, and include appropriate monitoring and interventions to address changes in condition, medication-related risks, skin integrity concerns, and specialized medical needs.	F0656		06/10/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received routine bathing and grooming services necessary to maintain personal hygiene and dignity, including failure to provide scheduled weekly bathing and failure to assist with facial hair grooming for 2 of 6 residents (R2 and R21) reviewed for activities of daily living (ADL) care. Findings include: R2's admission Minimum Data Set (MDS) dated 2/17/26, identified R2 had intact cognition and required assistance with activities of daily living (ADL)'s. R2's diagnoses included primary generalized osteoarthritis, atrial fibrillation, urinary tract infection (last 30 days), thyroid disorder, depression, chronic pain syndrome, urge incontinence, suicidal ideations, and weakness. R2's care plan printed 5/19/26, identified a self-care deficit related to falls. The care plan identified interventions and goals which included R2 would accept assistance with self-cares and would be dressed, groomed, and bathed per preferences. Interventions included assist of one staff member with dressing, assist of one staff member with grooming, assist of one staff member with bathing, provide assistance with oral cares in the morning, at bedtime, and as needed, and honor dressing and personal hygiene preferences. R2's bathing documentation from 4/1/26 to 5/19/26, identified R2 had scheduled bathing services once	F0677	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F0677 SS=D The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents are provided with scheduled weekly bathing and assistance with facial hair grooming. R2's weekly bathing schedule was reviewed with no adjustments made. Facial hair grooming was completed independently and immediately once needed equipment was provided. R21's has since discharged from facility. All other residents who are dependent with bathing and facial hair grooming have the potential to be affected.	06/10/2026

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F0677 SS = D	<p>Continued from page 12</p> <p>weekly. Documentation indicated R2 received a bath on 4/2/26, 4/26/26, 4/30/26, 5/12/26, and 5/15/26. R2 refused a bath on 4/16/26. Further review failed to identify documentation R2 received weekly bathing as scheduled, as the time between some completed baths exceeded one week. The record failed to identify additional refusals or documentation explaining why scheduled bathing services were not completed.</p> <p>During observation and interview on 5/17/26 at 10:41 a.m. R2's hair was standing up and appeared very greasy. R2 had a few long white chin hairs approximately one and a half to two inches in length. During interview, R2 stated she did not get a bath very often due to the facility being short staffed. R2 further stated she did not have access to tweezers, a shaver, or a mirror. R2 stated the chin hairs "bothers me and I don't like them at all," and stated, "when you notice them others can as well."</p> <p>During observation on 5/18/26 at 4:47 p.m. R2 was sitting at a table in the dining room. R2's hair was messy, standing up, and appeared greasy. R2 continued to have long white hairs present on her chin.</p> <p>During observation on 5/19/26 at 9:11 a.m. R2 was wheeling down the hallway in her wheelchair from the dining room to her room. R2's hair appeared brushed. Long white chin hairs continued to be present.</p> <p>R2's electronic medical record (EMR) failed to provide documentation to indicate grooming assistance had been offered or provided related to facial hair care.</p> <p>R21's comprehensive MDS dated 5/4/26, indicated intact cognition and required assistance with ADL's, including bathing. R21's diagnoses included cancer, cirrhosis (scarring of the liver that affects liver function), diabetes mellitus (a condition affecting blood sugar regulation), hip fracture (a break in the upper portion of the leg near the hip joint), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).</p> <p>R21's care plan printed 5/19/26, identified a self-care deficit related to femur fracture. The care plan identified goals for the resident to accept assistance with self-cares and to be dressed, groomed, and bathed per preferences. Interventions</p>	F0677	<p>Continued from page 12</p> <p>All like residents' weekly bathing and facial hair grooming needs been reviewed and revised, adjustments were made accordingly.</p> <p>All necessary Meeker Manor nursing staff received education utilizing Monarch Healthcare Management Activities of Daily Living/Maintain Abilities policy.</p> <p>Compliance audits will be completed one time per week for four weeks, one time every two weeks for four weeks, and one time per month for one month. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI</p> <p>Director of Nursing or designee is responsible party</p> <p>Compliance will be achieved on or before 6/10/2026.</p>	06/10/2026

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F0677 SS = D	<p>Continued from page 13 included occupational therapy (OT) per physician order, follow OT instructions, assist of one staff member with dressing, assist of one staff member with grooming, assist of one staff member with bathing, and provide assistance with oral cares in the morning, at bedtime, and as needed.</p> <p>R21's bathing documentation from 4/14/26 to 5/19/26, indicated bathing services once weekly. R21 refused a bath on 4/16/26 and received baths on 4/20/26, 4/30/26, and 5/12/26. Further review failed to identify documentation R21 received weekly bathing as scheduled, as the time between some completed baths exceeded one week. The record failed to identify additional refusals or documentation explaining why scheduled bathing services were not completed.</p> <p>During interview on 5/17/26 at 12:46 p.m. R21 stated "I have been here since middle of April and I have yet to have a bath or shower." R21 stated part of the issue was she had "a lot of wounds" and staff were waiting to get approval from the physician before giving her a shower, but stated "that has been a while." R21 further stated she had only had her hair washed once with a shampoo shower cap while in bed.</p> <p>During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated R2 and R21 required assistance with all activities of daily living (ADL's) and stated neither R2 nor R21 refused cares. LPN-A further stated residents were expected to receive at least one bath per week.</p> <p>During interview on 5/20/26 at 9:44 a.m. nursing assistant (NA)-A stated she had never heard that either R2 or R21 refused bathing and stated both residents required assistance with bathing. NA-A further stated if she noticed facial hair on a female resident, she would assist the resident with shaving. NA-A stated both residents should receive a bath weekly.</p> <p>During interview on 5/20/26 at 9:57 a.m. registered nurse (RN)-A stated residents were expected to receive bathing at least once weekly unless they refused, and staff were expected to try to follow resident preferences. RN-A stated R2 would occasionally require "a lot of convincing," but staff were generally able to encourage her to participate in care. RN-A stated R2 had previously lived in assisted living and had been very independent. RN-A further stated R2 required assistance with grooming and the facial hair "should be shaved." RN-A stated the facility had a facility-owned shaver</p>	F0677		06/10/2026

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F0677 SS = D	Continued from page 14 staff could use and the expectation was staff would assist the resident and address facial hair if noticed by staff. RN-A further stated she would have expected a bath to occur for R2 and R21 between 4/30/26 and 5/12/26. RN-A stated both residents were scheduled for Thursday evening bath days. RN-A stated if a resident refused bathing, the refusal should be documented in the medical record. RN-A further stated bathing schedules were discussed during morning meetings and, if bathing was noted to be overdue by a week, the scheduler would assist on the floor to help ensure additional baths were completed. During interview on 5/20/26 at 10:46 a.m. director of nursing (DON) stated each resident had their own bathing preferences and staff were expected to ensure those preferences were followed. The DON stated residents should receive bathing at least once weekly. The DON further stated staff were expected to assist residents with shaving facial hair when needed. Review of the facility policy titled "Activities of Daily Living (ADLs)/Maintain Abilities Policy," updated 3/31/23, identified the facility was responsible to provide person-centered care and services that honored and supported each resident's preferences, choices, values, and beliefs. The policy further identified the facility would provide necessary care and services to ensure residents' abilities in activities of daily living (ADL's) did not diminish unless unavoidable due to the resident's clinical condition. The policy identified the facility would provide care and services related to hygiene needs, including bathing, dressing, grooming, and oral care. The policy further identified residents unable to complete ADL's independently would receive necessary services to maintain grooming and personal hygiene.	F0677		06/10/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence,	F0690	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted	06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355	
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F0690 SS = D	<p>Continued from page 15 based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure appropriate care and services were provided for the management of an external urinary catheter system, including failure to obtain physician orders and implement care instructions for cleaning, disinfecting, and changing the condom catheter drainage bag for 1 of 1 resident (R1) reviewed for urinary catheter care.</p> <p>Findings include:</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 3/30/26, identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).</p> <p>R1's signed physician orders dated 4/29/26,</p>	F0690	<p>Continued from page 15 this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>F0690 SS=D</p> <p>The process for satisfying this requirement has been reviewed and revised as needed, to ensure care instructions for cleaning, disinfecting and changing condom catheter drainage bags.</p> <p>R1's drainage bag change order has been entered into facility's electronic documentation record to be changed weekly.</p> <p>Currently no other residents in the facility utilize condom catheter.</p> <p>All necessary Meeker Manor nursing staff received education utilizing Monarch Healthcare Management Disinfection of Urinary Drainage Bag policy.</p> <p>Compliance audits will be completed one time per week for four weeks, one time every two weeks for four weeks, and one time per month for one month. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI</p> <p>Director of Nursing or designee is responsible party</p> <p>Compliance will be achieved on or before 6/10/2026.</p>	06/10/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 05/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355</p>		
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<p>F0690 SS = D</p>	<p>Continued from page 16 indicated use of a condom catheter at bedtime. Review of the electronic medical record (EMR) failed to identify physician orders or documented instructions related to cleaning, disinfecting, monitoring, or routine changing of the catheter drainage bag associated with the condom catheter system.</p> <p>During observation on 5/19/26 at 11:57 a.m. R1's catheter drainage bag was observed hanging on the side rail in R1's bathroom. Observation and record review failed to identify documentation the drainage bag was routinely cleaned, disinfected, monitored, or replaced in accordance with accepted standards of practice.</p> <p>During interview on 5/20/26 at 9:44 a.m. licensed practical nurse (LPN)-A stated R1 used a condom catheter at night that was attached to an overnight drainage bag. LPN-A reviewed the EMR and confirmed there were no physician orders addressing when the drainage bag should have been changed or instructions for cleaning or disinfecting the bag. LPN-A stated staff were expected to follow physician orders and facility protocols related to catheter care and infection prevention practices.</p> <p>During interview on 5/20/26 at 9:57 a.m. registered nurse case manager (RN)-A stated there was an order in the computer for the condom catheter to be applied at bedtime and removed at HS. RN-A stated the drainage bag change schedule should have been included in the physician orders and the bag should have been changed weekly. RN-A reviewed the EMR and confirmed there were no orders related to changing, cleaning, or disinfecting the drainage bag.</p> <p>During interview on 5/20/26 at 10:46 a.m. the director of nursing (DON) stated the facility expected catheter drainage equipment to have clear physician orders and nursing instructions regarding care, cleaning, monitoring, and replacement schedules. The DON stated catheter care should have included monitoring output and assessing for signs and symptoms of irritation or infection, including regular skin checks. The DON further stated drainage bags should have been changed weekly and documented on the treatment administration record (TAR). The DON confirmed the facility was unable to provide evidence orders or documented guidance were in place for R1's condom catheter drainage bag care.</p> <p>The facility policy titled, "Condom/External Catheter Care," dated 1/2025, identified male external catheters were used for residents with urinary incontinence and required daily care to maintain</p>	<p>F0690</p>		<p>06/10/2026</p>

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F0690 SS = D	Continued from page 17 cleanliness, safety, and proper functioning. The policy directed staff to remove, dispose of, and replace external catheters every 24 hours and to clean and assess the penis daily for redness, bruising, or open areas that could indicate improper fit or skin breakdown. The policy further instructed staff to practice good hygiene, including handwashing and cleaning of the penis during catheter application and drainage bag emptying, and to ensure proper application techniques to avoid complications and injury. The facility policy titled, "Disinfection of Urinary Drainage Bag," revised 12/2023, identified the purpose of the policy was to clean and disinfect urinary drainage bags and prohibit the growth of bacteria. The policy directed staff to cleanse catheter and tubing connection points with an alcohol swab prior to disconnecting the drainage bag, disinfect the drainage bag daily when removed from the resident, rinse the inside of the bag with 55-65 cc of vinegar, allow the exterior to air dry, and change the drainage bag to a new appliance on bath day. The policy further identified staff were to monitor and record urinary output and maintain appropriate catheter care supplies in the resident room.	F0690		06/10/2026

Minnesota Department of Health

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 5/17/26 to 5/20/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.</p> <p>The following complaints were reviewed: NO licensing orders were issued.</p>	20000		06/10/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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20555	Continued from page 5 should be responsible to ensure oversight occurs.	20555		06/10/2026
20910	<p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> <p>Rehab - Incontinence</p> <p>CFR(s): MN Rule 4658.0525 Subp. 5 A.B</p> <p>Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:</p> <p>A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and</p> <p>B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure appropriate care and services were provided for the management of an external urinary catheter system, including failure to obtain physician orders and implement care instructions for cleaning, disinfecting, and changing the condom catheter drainage bag for 1 of 1 resident (R1) reviewed for urinary catheter care.</p> <p>Findings include:</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 3/30/26, identified R1 had intact cognition and required assistance with activities of daily living (ADL's). R1's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition in which the heart cannot pump blood effectively), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), stroke (damage to the brain caused by interrupted blood flow), malnutrition (lack of proper nutrition due to inadequate intake or absorption), anxiety disorder (a condition involving excessive worry or fear), and depression (a mood disorder causing persistent sadness or loss of interest).</p>	20910	Completed	06/10/2026

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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/18/2026. At the time of this survey, Meeker Manor Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES</p> <p>(K-TAGS) TO:</p> <p>Health Care Fire Inspections</p> <p>State Fire Marshal Division</p>	K0000		06/02/2026

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 reverse for further 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
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K0000 Bldg. 01	<p>Continued from page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. <p>Meeker Manor is a one-story building with a partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 55 beds and had a census of 43 at the time of the survey.</p> <p>The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:</p>	K0000		06/02/2026

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K0372 SS = F Bldg. 01	<p>Subdivision of Building Spaces - Smoke Barrie</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.2.2. These deficient findings could have a widespread impact on residents within the facility.</p> <p>Findings include:</p> <p>On 05/18/2026 at 10:17 AM, it was revealed by observation that a penetration in the smoke barrier leading to 100 lane was not properly sealed with fire caulking.</p> <p>On 05/18/2026 at 10:18 AM, it was revealed by observation that a penetration in the smoke barrier leading to 200 lane was not properly sealed with fire caulking.</p> <p>On 05/18/2026 at 10:57 AM, it was revealed by observation that a penetration in the smoke barrier leading to 300 lane was not properly sealed with fire caulking.</p> <p>On 05/18/2026 at 10:59 AM, it was revealed by observation that a penetration in the smoke barrier leading to 400 lane was not properly sealed with fire caulking.</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p>	K0372	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>K0372-</p> <p>Based off observation during the walk through, penetrations in the smoke barriers were identified with deteriorated caulking and visible gaps which failed to maintain smoke barriers.</p> <p>These findings could have a widespread impact on the residents of the facility</p> <p>The Maintenance Director was reeducated using the regulation</p> <p>The penetrations were properly sealed with approved fire/smoke barrier caulking to restore the integrity of the smoke barrier.</p> <p>To ensure compliance with the regulation, the facility will conduct audits of smoke barrier penetrations weekly for four weeks, followed by monthly audits for two months. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI.</p> <p>Maintenance Director or designee is responsible party.</p> <p>Date of compliance on 6/2/2026</p>	06/02/2026

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NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355	
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K0321 SS = D Bldg. 01	<p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms</p> <p>b. Laundries (larger than 100 square feet)</p> <p>c. Repair, Maintenance, and Paint Shops</p> <p>d. Soiled Linen Rooms (exceeding 64 gallons)</p> <p>e. Trash Collection Rooms (exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have an isolated impact on residents within the facility.</p> <p>Findings include:</p>	K0321	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>K0321-</p> <p>Based off observation during the walk through, room 210 was being used to store combustible items and the door did not have a self-closing device.</p> <p>This deficient finding could have an isolated impact on residents within the facility.</p> <p>The Maintenance Director was reeducated using the regulation</p> <p>An approved automatic self-closing device was installed on the door, and the door was tested to ensure it closed and latched properly.</p> <p>To ensure compliance with the regulation, audits of storage areas and automatic self-closing will be completed weekly for four weeks, followed by monthly audits for two months. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI.</p> <p>Maintenance Director or designee is responsible party.</p> <p>Date of compliance on 6/2/2026</p>	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355	
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K0321 SS = D Bldg. 01	Continued from page 4 On 05/18/2026 at 10:29 AM, it was revealed by observation that room 210 was being used to store combustible items and the door did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		06/02/2026
K0351 SS = D Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 6.2.7.1, and 8.3.1.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/18/2026 at 10:22 AM, it was revealed by observation that the sprinkler head in the Shower Room in the 100 wing was missing the escutcheon that goes around the sprinkler head. An interview with the Maintenance Director verified	K0351	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K0351 Based off observation during the walk through, It was identified that the shower room in the 100 wing was missing the escutcheon that goes around the sprinkler head. This deficient finding could have an isolated impact on residents within the facility. The Maintenance Director was reeducated using the regulation The missing escutcheon was replaced, and the sprinkler assembly was inspected to ensure it was properly installed and maintained in accordance with Life Safety Code The Maintenance Director will include sprinkler heads and escutcheon plates in monthly environmental and Life Safety inspections to ensure all components remain intact and properly installed.	06/02/2026

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K0351 SS = D Bldg. 01	Continued from page 5 this deficient finding at the time of discovery.	K0351	Continued from page 5 The facility will conduct audits of sprinkler heads and escutcheon plates once weekly for four weeks, followed by monthly audits for two months, to ensure all components remain intact and properly installed. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI. Maintenance Director or designee is responsible party. Date of compliance on 6/2/2026	06/02/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(2). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/18/2026 between 9:00-11:30 AM, it was	K0353	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K0353 Based off observation during the walk through, the sprinklers located in the housekeeping storage rooms in each wing of the building were found to have signs of corrosion. This deficient finding could have an isolated impact on residents within the facility. The Maintenance Director was reeducated using the regulation The affected sprinkler heads were replaced, and the system was inspected to ensure all sprinkler components were in proper working condition. The Maintenance Director or designee will perform audits of sprinkler heads in housekeeping storage	06/02/2026

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K0353 SS = D Bldg. 01	Continued from page 6 revealed by observation that the sprinkler heads in the Housekeeping Storage rooms in each wing of the building were showing signs of corrosion. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 6 rooms weekly for four weeks, followed by monthly audits for two months. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI. Maintenance Director or designee is responsible party. Date of compliance on 6/2/2026	06/02/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly use electrical equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4.2.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/18/2026 at 11:11 AM, it was revealed by observation that the resident's bed in Room 403 was plugged into a power strip that was not properly listed to be used with PCREE. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K0920 Based off observation during the walk through, a power strip located in Room 403 was identified as not being properly listed for use with Patient Care-Related Electrical Equipment (PCREE). This deficient finding could have an isolated impact on residents within the facility. The Maintenance Director was reeducated using the regulation The power strip was immediately removed from service upon discovery to eliminate any potential safety risk The facility will implement a monitoring process to ensure that only approved and properly listed power strips are used with Patient Care-Related Electrical Equipment (PCREE).	06/02/2026

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K0920 SS = D Bldg. 01		K0920	Continued from page 7 The Maintenance Director or designee will conduct weekly audits for four weeks, followed by monthly audits for two months. Non-compliance will be immediately corrected at the time of occurrence with results reviewed at QAPI. Maintenance Director or designee is responsible party. Date of compliance on 6/2/2026	06/02/2026