STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Meadows At Luther - Madelia	**503 BENZEL AVENUE SW , MADELIA, Minnesota, 56062**

(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 4/27/26-4/28/26, 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		
F0000	INITIAL COMMENTS On 4/27/26-4/28/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be 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, the facility must acknowledge receipt of the electronic documents.	F0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/28/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/28/2026**

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Living Meadows At Luther - Madelia	**503 BENZEL AVENUE SW , MADELIA, Minnesota, 56062**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/28/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Living Meadows at Luther-Madelia 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. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/11/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245522	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. LIVING MEADOW AT LUTHER - MADELIA is a 1-story building with no basement. The facility was constructed at 4 different times. The original building was constructed in 1958 with construction determined to be of Type II (000) construction. An addition constructed in 1973 and was also determined to be of Type II (000) construction. An addition constructed in 1993 and was also determined to be of Type II (000) construction. An addition constructed in 2001 and was also determined to be of Type II (000) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The entire facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection	K0000		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245522	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

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K0000 Bldg. 01	Continued from page 2 in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/11/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain Patient Care Related Electrical Equipment per NFPA 99 (2012 edition), Health Care Facilities Code. Sections 10.3, 10.5.2, 10.5.2.1.2 and 10.5.6 This deficient finding could have a widespread impact on the residents within the facility.	K0921	K0921- PCREE Testing A. Corrective Action a. A system will put in place to inspect and test all electronic devices used directly for resident care. These devices include but are not limited to; CPap machines, Nebulizers, electric beds, O2 Concentrators and Suction Machines. b. A checklist will be used for nursing home specific devices c. A binder will be made to hold documentation supporting the inspections and testing results and will be kept in the Environmental Service Directors Office. B. Prevention of Recurrence a. Testing intervals will be established based on usage b. Testing will be conducted routinely and if any repairs are made to the equipment. c. Testing will be conducted on all new equipment prior to being put into service. d. Testing will be conducted by the facility maintenance department personnel. C. Completion a. A PCREE Inspection & Test Checklist has been created to facilitate testing of Specific PCREE used at this facility on 5-15-2026. b. All equipment will be inspected and documented by 7-1-2026.	05/18/2026

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K0921 SS = F Bldg. 01	Continued from page 3 Findings include: On 04/28/2026 at 10:36 AM, it was revealed by a review of available documentation and staff interview that the facility could not provide documentation showing that Patient-Care Related Electrical Equipment (PCREE) had been inspected within the last year. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0921		05/18/2026
K0353 SS = E 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, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system 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(5), and 5.2.2.2. These deficient findings could have an patterned impact on residents within the facility. Findings include:	K0353	K0353- Sprinkler Deficiencies A. Corrective Action a. The flex conduit was removed and rerouted from the sprinkler pipe. b. The Red fire alarm wire was also removed and rerouted from the sprinkler pipe. B. Prevention of Recurrence a. Any future work performed that requires hanging conduit, plumbing or cabling of any sort will require it be “tied up” away from and not attached to any sprinkler piping or supports to avoid weight loading the system. b. A visual inspection of the sprinkler pipe will be conducted after any work performed to identify any subsequent findings of conduit, wire, or other weight loading devices. Any such discrepancies that are found will be removed and/or rerouted from the piping. c. This inspection will be conducted by the facility maintenance department. C. Completion The removal of the flex conduit and fire wire were completed on 5-11-2026.	05/18/2026

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K0353 SS = E Bldg. 01	Continued from page 4 1. On 04/28/2026 at 11:35 AM, it was revealed by observation that there was a flexible conduit zip tied to the sprinkler pipe in the Northwest air handler room. 2. On 04/28/2026 at 11:35 AM, it was revealed by observation that there was a fire red wire zip tied to the sprinkler pipe in the Northwest air handler room. An interview with the Environmental Service Director verified these deficient findings at the time of discovery.	K0353		05/18/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING 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. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: 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, 8.5.2.2, and 8.5.6.2. These deficient findings could have an patterned impact on the residents within the facility. Findings include: On 04/28/2026 at 11:13 AM, it was revealed by observation that an unsealed penetration exists in the smoke barrier above the ceiling at the kitchen door near the delivery entrance. 2. On 04/28/2026 at 11:14 AM, it was revealed by observation that an unsealed penetration around a sprinkler pipe exists in the smoke barrier above the ceiling at the watermain door near the delivery entrance.	K0372	K0372- Smoke Barriers A. Corrective Action 1. Fire rated caulk was used to fill the penetration listed in the inspection report at the Kitchen door. 2. Fire rated caulk was used to fill the penetration listed in the inspection report at the water main door overhead. B. Prevention of Recurrence a. Any future work done requiring penetration of the smoke barriers will be inspected for proper filling with fire rated caulking prior to completion of the work. b. A visual inspection of the Smoke Barrier will be conducted to identify any subsequent findings of unsealed penetrations. Any such discrepancies that are found will be filled using Fire rated caulk. c. This action was completed by the maintenance department. C. Completion This corrective action was completed on 5-12-2026.	05/18/2026

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K0372 SS = E Bldg. 01	Continued from page 5 An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0372		05/18/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 24, 2026

Administrator
Living Meadows At Luther - Madelia
503 BENZEL AVENUE SW
MADELIA, MN 56062

RE: CCN: 245522
Cycle Start Date: April 28, 2026

Dear Administrator:

On May 21, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us