DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 5, 2025

Administrator
Living Meadows At Luther - Madelia
503 Benzel Avenue Sw
Madelia, MN 56062

RE: CCN: 245522
Cycle Start Date: March 26, 2025

Dear Administrator:

On April 29, 2025, the Minnesota Departments 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

May 5, 2025

Administrator
Living Meadows At Luther - Madelia
503 Benzel Avenue Sw
Madelia, MN 56062

Re: Reinspection Results
Event ID: 417X12

Dear Administrator:

On April 24, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 26, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 8, 2025

Administrator
Living Meadows At Luther - Madelia
503 Benzel Avenue Sw
Madelia, MN 56062

RE: CCN: 245522
Cycle Start Date: March 26, 2025

Dear Administrator:

On March 26, 2025, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 June 26, 2025 (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 September 26, 2025 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING MEADOWS AT LUTHER - MADELIA	503 BENZEL AVENUE SW MADELIA, MN 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
E 000	Initial Comments On 3/24/25 through 3/26/25 a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 3/24/25 through 3/26/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 of compliance. 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.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/18/25

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

Electronically Signed | 04/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R13) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include: R13's facesheet received 3/26/25, included diagnoses of Alzheimer's disease with early onset, osteoarthritis and spasticity (a condition with increased muscle tone, stiffness and involuntary muscle contractions). R13's quarterly (MDS) assessment dated 12/24/24, indicated R13 had severely impaired cognition, and no behaviors. Activities of daily living (ADL's) included R13 uses a wheelchair and is dependent on staff for transfers, bed mobility, locomotion and for eating. R13 has no current skin issues but is at high risk for development of pressure ulcer. R13 has had no recent weight loss or gain and is incontinent of	F 686	F 686 R13 was re-assessed for positioning schedule on 4/11/2025. Repositioning policy was reviewed and updated on 4/10/2025. All current residents in the facility were audited to determine if they require scheduled repositioning per their care plan. If the audit determines a resident requires scheduled repositioning, individual repositioning flowsheets will be initiated according to the care plan. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All clinical staff (Licensed nurses, TMA, NA) will be educated on the facility policy Repositioning by compliance date Education included: ensuring residents are repositioned per their care plan and the repositioning is documented on the resident repositioning flow sheet. Education on the policy was initiated on	

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F 686	Continued From page 2 bowel and bladder. R13's Braden Scale for Predicting Pressure Sore Risk dated 12/24/24, had a score of 12 indicating R13 is at risk for skin breakdown. R13's care plan dated 4/10/24, indicated R13 has a potential for impaired skin integrity and is high risk for skin breakdown with interventions including: apply ointments/medications as ordered, use pressure reducing devices (mattress on her bed and cushion in her chair), assist with hygiene and general skin care. Avoid using hot water for cleaning. Reposition every two hours while in bed and offer fluids with position changes. Monitor skin daily with cares and report changes to charge nurse. Use moisturizer with cares and keep skin clean and dry. Use mechanical lift for transfers. Use incontinence pads and barrier cream to peri area as needed. Keep linen clean, dry and wrinkle free. Reposition every hour when up in chair. Increase protein in diet as appropriate and dietary consult as needed. A provider progress note dated 3/20/24, indicated R13 had a stage 2 pressure injury (open wound that affects both the top and bottom layers of the skin) of sacral region (large triangular bone at the base of the spine). The open area on left sacrum was 1.8 centimeter (cm) x 1 cm x 0.2 cm. Adjacent to this wound is a pinpoint open area. Drainage is minimal and green. Edges are well defined and slightly macerated (skin is soft, wet or soggy to the touch and can delay wound healing). Right sacrum 1.2 cm x 0.2 cm x 0.1 cm think slit. No drainage and no odor. Will change treatment to cleansing with acetic acid 0.25%, skin prep to the intact periwound skin, applying	F 686	4/14/2025. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) The Director of Nursing will complete audits on 10 random residents weekly for 3 months to ensure repositioning has been completed per Repositioning policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 4/18/2025	

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F 686	Continued From page 3 calcium alginate AG (wound dressing that can absorb large amounts of exudate and has antimicrobial properties) to the wound bed and cover with a gentle adhesive foam dressing changing every other day or sooner if needed. Patient does rely on nursing staff for her repositioning and toileting needs. She does not have an air mattress on her bed at this time as she has a lip mattress. Staff are looking at options to apply an air overlay. Review of Skin Problems notes: 3/13/25: Right buttock skin is intact and within normal limits. Left buttock abrasion, scant drainage present, wound bed is 100% red, granulating tissue measuring 1.2 cm x 0.8 cm by 0.2 cm. Macerated tissue measuring 0.2 cm by 0.2 cm. Provider notified. 3/14/25: Abrasion to the left buttock continues to be open with a small 0.3 cm by 0.5 cm abrasion right below the current abrasion. 3/15/25: Abrasions x 2 to left buttock area. Area cleansed and dressing applied as ordered. Right buttock skin starting to slough, at this time is not open and cream was applied. 3/19/25: Dressing change to abraised [sic] tissue to left inner buttock completed. Small abraised [sic] tissue noted on 3/14/25 below current abraised [sic] site remains apparent. Also has abraised [sic] tissue to right inner buttock measuring approximately 0.2 cm x 0.2 cm. Physician notified of changes. 3/20/25: See provider note (above). 3/22/25: Left and right inner buttock/sacrum; previous dressing soiled and removed to be changed. Moderate purulent drainage present on dressing. Wound appears light red, granulating tissue present.	F 686		

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F 686	Continued From page 4 On observation 3/24/25 at 12:10 p.m., R13 was seated in her Broda (positioning chair) chair in the dining room. R13 was being assisted by staff with meal. On observation 3/25/25 at 8:44 a.m., R13 was seated in her Broda chair and was assisted from the dining room back to her room after breakfast by nursing assistant (NA)-A. At 8:45 a.m., R13 with assist from NA-A, and NA-B and a mechanical lift, was placed in her bed and positioned on her right side. NA-A and NA-B stated R13 is repositioned every two hours. NA-A and NA-B did not check R13's pad at this time. R13's bed did not have an air mattress or overlay present. Continuous observation including interviews, was started 3/25/25 at 8:45 a.m.: 9:15 a.m. R13 remains on her right side asleep. No staff into room. 9:43 a.m. R13 remains on her right side. No staff into room. 10:20 a.m. R13 remains in the same position with no staff entering the room. 10:46 a.m. R13 continues on her right side. No staff entered the room. 11:09 a.m. no change in position. Laundry staff entered room to put laundry away and activities staff changed the calendar in the room. 11:30 a.m. R13 continues on her right side. No staff into room. At 11:32 a.m. activities assistant (AA)-A looked into R13's room and stated R13 usually comes to sensory class at 11:00 a.m. but didn't come this morning. 11:38 a.m., license practical nurse (LPN)-A stated R13 was given a suppository this morning around 9:45 a.m. so they didn't get her up for sensory class.	F 686		

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F 686	Continued From page 5 11:54 a.m. no change in R13's position and no staff into the room. On observation and interview 3/25/25 at 12:00 p.m., NA-A and LPN-A entered the room. NA-A stated she was unsure if R13 had been repositioned since she assisted with putting her to bed as she isn't working R13's hallway. NA-A and LPN-A checked R13's pad. Stool was present and was smeared onto sacral dressing that was present on left sacral area. LPN-A after cleaning up stool, removed sacral dressing and stool was present under the dressing along with serosanguinous (bodily fluid with mixture of serum and blood) drainage. LPN-A cleansed wound with acetic acid 0.25% (antimicrobial properties) placed on a sterile 4x4 guaze pad, Xerofoam (sterile petrolatum-based gauze dressing used as a non-adherent dressing and promotes a moist wound environment) placed onto wound and covered with adhesive dressing. LPN-A measured wound on left sacral area which was 1.5 cm by 1.0 cm with a white spot present in the middle of the wound. LPN-A stated she was unsure what that was but the wound was improved from the last time she changed dressing. Right sacral area had no open area or abrasions present. LPN-A indicated the redness on both buttocks was from previous pressure sores that come and go. R13 with assist of mechanical lift and LPN-A and NA-A was placed in her chair and taken to dining room for lunch. R13's medication administration record (MAR) indicated (Dulcolax) Bisacodyl 10 mg suppository dose rectal daily as needed for constipation was given 3/25/25 at 7:52 a.m. On interview 3/25/25 at 1:10 p.m., LPN-A	F 686		

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F 686	Continued From page 6 indicated the suppository was given earlier than she had initially thought and R13 should been respositioned every 2 hours. On interview 3/25/25 at 1:59 p.m., NA-C stated she had not laid R13 down in her bed so was not sure when she needed to be repositioned. NA-C confirmed she had not repositioned R13 at all this morning and stated she was alerted to R13 not being repositioned and staff are now using a reposition sheet. On interview 3/26/25 at 10:48 a.m., the director of nursing (DON) stated she would expect staff to reposition R13 every 2 hours as indicated by the care plan. The DON indicated she has initiated a paper form for reminders for staff to reposition R13 as she had been made aware of R13 not getting repositioned yesterday. Facility Repositioning policy dated 11/19/24, included: - Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. -Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals -Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. -Positioning the resident on an existing pressure ulcer should be avoided in most situations since it put additional pressure on tissue that is already	F 686		

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F 686	Continued From page 7 compromised and may impeded healing. - A turning/repositioning scheduled includes a continuous consistent schedule for changing the residents position and realigning the body. -Residents who are in bed should be on at least an every 2 hour repositioning schedule or as determined by assessment.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) services were provided according to the assessed need for 1 of 1 resident (R24) reviewed for positioning and mobility. Findings include:	F 688	F 688 R24 AAROM program was reviewed on 4/10/2025 and remains appropriate. Range of motion exercise policy was reviewed and updated on 4/10/2025. All current residents in the facility were audited to determine current residents requiring range of motion programs. If the	4/18/25

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LIVING MEADOWS AT LUTHER - MADELIA	503 BENZEL AVENUE SW MADELIA, MN 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
F 688	Continued From page 8 R24's facesheet printed 3/26/26, included diagnoses of heart failure, peripheral neuropathy (nerves located outside the brain and spinal cord are damaged causing weakness, numbness and pain), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), and osteoarthritis (degenerative disease with pain and stiffness) of multiple joints. R24's quarterly Minimum Data Set (MDS) assessment dated 2/26/26, indicated R24 was cognitively intact, had no behaviors including refusal of care and required assist of 1-2 staff for dressing and bed mobility and assist of 2 staff for toileting and transfers. The MDS included R24 has frequent pain which interferes with activities of daily living and rated pain at a level of 3 on scale of 1-10. R24's medications included opioid use, antidepressant, diuretic, hypoglycemic and antiplatet agent. R24's care plan last revised 2/26/25, indicated R24 had a self care deficit related to pain, decreased mobility, muscle weakness, and fatigue. Interventions included assist of 1-2 for dressing, and grooming. Toileting and transfer require assist of 2. Special directions included encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares (as tolerated/allowed by resident). May be completed when seated in wheelchair or when lying in bed. Report concerns/refusals to nurse. See therapy communication for additional information. On observation and interview 3/24/25 at 1:19 p.m., R24 stated "staff don't do exercises with me	F 688	audit determines a resident requires a range of motion program, program and documentation will be initiated per policy. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All nursing assistants and the restorative aide will be educated on the facility policy Range of Motion exercises by compliance date. Education included: range of motion is completed per care plan and documented according to facility protocol. Education on the policy was initiated on 4/14/2025. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2)The Director of Nursing will complete audits on 5 random residents weekly for 3 months to ensure range of motion is provided and documented per facility policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3)Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 4/18/2025	

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	245522	A. BUILDING _____ B. WING _____	03/26/2025

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F 688	Continued From page 9	F 688		

at all." On the wall in R24's room, ROM exercises for elbows and shoulders was posted. R24 indicated she was in therapy and they ordered these exercises but no one ever helps her do them. R24 stated she does go to restorative nursing services one to two times per week and they help her do other exercises. R24 added she isn't able to do the exercises by herself as it is too painful to move her arms very far without some assistance from staff.

R24's Rehab Communication form dated 1/6/25, by OT-C for nursing staff included "Please complete AAROM to bilateral upper extremities with AM and PM cares as patient tolerates either seated in wheelchair or lying in bed." Exercises to complete are attached.

R24's Occupational Therapy Discharge Summary for dates of service 12/10/24 - 1/6/25, signed by occupational therapist (OT)-C included discharge to current skilled nurse facility with bilateral upper body AAROM twice a day by nursing to shoulder flexion/extension, shoulder abduction/adduction, shoulder horizontal abduction/adduction for 10 reps per motion. Prognosis is good with consistent staff follow-through.

R24's treatment records for 1/8/25 thru 3/26/25, for encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares included 3 missed out of 77 opportunities with the initials by the nurse on duty that day completing the documentation.

On interview 3/25/25 at 4:47 p.m., OT-C indicated R24 was in therapy until 1/6/25. OT-C stated R24 is compromised in her shoulders and elbows and

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F 688	Continued From page 10	F 688		

needs ROM one to two times a day to maintain her motion. OT-C indicated AAROM is short for "active assistance range of motion" meaning staff should be assisting her.

On interview 3/25/25 at 4:52 p.m., R24 indicated no one did ROM with her today but she did attend restorative therapy.

On interview 3/26/25 at 9:52 a.m., nursing assistant (NA)-D indicated NA's are responsible for doing ROM and R24 does her ROM exercises on her own. NA-D indicated they do not document if ROM is done or if resident refuses.

On interview 3/26/25 at 9:54 a.m., NA-B indicated R24 does her ROM exercises on her own. NA-B added we will assist if she asks for help. NA-B indicated they don't document if ROM is completed or if resident refuses.

On interview 3/26/25 at 9:58 a.m., registered nurse (RN)-A stated NA's are responsible to complete ROM but R24 can do her ROM exercises on her own. When asked if staff are completing the AAROM, RN-A indicated "I think she is completing them or I assume it is getting done when I document it is completed."

On observation and interview 3/26/25 at 10:13 a.m., R24 was dressed and seated in her wheelchair in her room. R24 stated she needs staff to help her with her exercises and she is unable to do them without assistance. R24 demonstrated she could lift her arms approximately 2 inches without assistance and discomfort. R24 added they have done ROM on her once since January when it was ordered. R24 indicates staff never offer, never do the

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F 688	Continued From page 11 exercises with her when assisting her to get dressed and thinks staff "just don't care." On interview 3/26/25 at 10:44 a.m., the director of nursing (DON) stated if it is on the treatment record I would expect the nurse prior to documenting completion to check with the NA's to ensure it was offered and completed or check with the resident to ensure staff are completing it. The DON indicated she would expect the NA's to be completing this with the resident per therapy recommendations. Facility Range of Motion Exercises policy dated 12/10/24, included: -Review the resident's care plan to assess for any special needs of the resident. -Be gentle with the resident and do not rush the procedure. -If the resident becomes weak, or complains of pain, cease the exercise and summon the staff/charge nurse. -Support the extremity at the joint as it is being exercised. -Move each joint through its range of motion three times unless otherwise instructed. -Move each joint gently, smoothly and slowly through it range of motion -Remember to stop an exercise before the point of pain. -Documentation should include the date and time performed, name and title of the individual who performed the procedure, the type of ROM exercise given, whether the exercise was active or passive, how long the exercise was conducted, if and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure, any problems or complaints made by the resident related to the	F 688		

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F 688	Continued From page 12 procedure, if the resident refused the treatment, the reason why and the intervention taken. The signature and title of the person who is record this data.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dish machine chemical sanitization solution was monitored to ensure dishes were properly sanitized. In addition, the facility failed to ensure temperatures were monitored in 1 of 2 kitchen freezers and 1 of 3 refrigerators (coolers). This had the potential to affect all 36 residents who resided in the facility. Findings include:	F 812	Dish Machine Chemical Sanitation- Binder for monitoring chemical log books was moved closer to dishwashing area. Employees were re-trained on importance of monitoring and logging chemicals at each meal service. They were also instructed that this is a low temperature dishwasher and wash temperatures should be 120 degrees F and 50ppm hypochlorite (bleach). Dishwashers as	4/14/25

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F 812	Continued From page 13 Initial kitchen tour was conducted on 3/24/25 at 10:38 a.m., with cook (C-A) and dietary manager (DM)-A. Informed during the tour that the dish machine used chemicals for disinfection (low temperature dish machine). No chemical monitoring logs were visible in or around the dish machine area. Dietary aide (DA)-A was asked to provide the logs. The logs were in a binder on the other side of the kitchen. The paper logs indicated chemical monitoring was done very infrequently. A document titled Dish Machine Temperature & Sanitization Record indicated water temperature and sanitation solution was to be monitored daily with each of the three meals. Results were as follows: -- March 2025: chemical disinfectant had been tested 6 out of 69 opportunities. -- February 2025: 25 out of 84 opportunities -- January 2025: 26 out of 93 opportunities -- December 2024: 11 out of 93 opportunities -- November 2024: 1 out of 90 opportunities -- October 2024: 7 out of 90 opportunities -- September 2024: no documentation -- August 2024: no documentation -- July 2024: no documentation -- June 2024: 1 out of 90 opportunities -- May 2024: 6 out of 93 opportunities DA-A stated he was aware the disinfectant solution and temperature should be monitored and documented with each meal service, but did not have an explanation for why it had not been done. DM-A, who was new to the role, was unaware it had not been monitored. During an interview on 3/24/25 at 12:55 p.m., C-B	F 812	well as other staff operating the dishwasher are responsible for the implanting of this procedure. Log books will be checked daily for completion. At each of our staff meetings, all staff will be retrained on the importance of this procedure as well On March 24th 2025 the actual process began and will continue per procedure. Refrigerator and Freezer Temperature Logging Freezers and Refrigerators have both a hanging internal thermometer and have a digital reading thermometer. Staff were all re-trained on the importance of logging the temperatures for all Freezers and Refrigerators and both shifts. They were trained that the storage temperatures in the refrigerators must be between 35 to 39 degrees F. They were also trained that this procedure must be done twice daily. Freezers must maintain a temperature below freezing. Dietary Cooks and Dietary Aides are responsible for following this procedure. Log books will be checked daily for completion. The importance of this procedure has been explained to staff and will be followed up on during our future staff meetings. On March 24th 2025 the process began and will continue per procedure.	

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F 812	Continued From page 14 was operating the dish machine. Using a chemical test strip, C-B tested the disinfectant solution in the dish machine, which registered at an acceptable level of 50 parts per million (PPM) and the gauge on the dish machine indicated an acceptable temperature of 128 degrees Fahrenheit (F). C-B admitted he knew the temperature and sanitizing solution should be monitored, but did not have a reason why it had not been documented. C-B acknowledged monitoring the chemical solution and temperature was important to kill bacteria on dishware. FREEZER & REFRIGERATOR TEMPERATURES During the initial kitchen tour on 3/24/25 at 10:41 a.m., C-A opened the silver 2-door freezer and couldn't find a thermometer. C-A immediately obtained a thermometer and added it to the freezer. The foods in the freezer were frozen solid to the touch. Temperature logs for the 2-door silver refrigerator and 2-door silver freezer were reviewed. The temperature log was titled Cook Temperature Sheet and on the bottom was a section titled Freezer and Cooler Temperatures. The last time any temperature was recorded was on 1/20/25. Temperatures at that time were in acceptable temperature ranges: Silver cooler: 36 degrees F Silver freezer: 2 degrees F During an interview on 3/25/25 at 11:11 a.m., C-A stated the morning and evening cooks were supposed to document temperatures of each refrigerator and freezer and record it. C-A stated, "We just weren't doing it." C-A acknowledged food needed to be maintained at correct temperatures to prevent spoiling and	F 812		

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F 812	Continued From page 15 foodborne illness. During an interview on 3/25/25 at 11:30 a.m., DM-A acknowledged she had just started her role and had not been aware of the lack of monitoring and would correct it right away. On 3/26/25 at 12:15 p.m., the administrator was informed of kitchen findings. Facility Cleaning Dishes/Dish Machine policy dated 2021, indicated all dishware would be cleaned, rinsed and sanitized after each use. The dish machine would be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy indicated for low temperature dishwasher, wash temperature should be 120 degrees F., and 50 PPM hypochlorite (bleach). Facility Dish Machine Temperature Log policy dated 2021, indicated dishwashing staff would monitor and record dish machine temperatures to assure proper sanitizing of dishes. The director of food and nutrition services would post a log near the dish machine for the staff to document temperatures. Staff would record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition would spot check the log to assure temperatures were appropriate and staff were correctly monitoring dish machine temperatures. Facility Food Storage policy dated 2021, indicated food would be stored at appropriate temperatures. Temperatures for refrigerators should be between 35 to 39 degrees F. Thermometers should be checked at least two times a day. Every refrigerator must be equipped	F 812		

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F 812	Continued From page 16 with an internal thermometer. Frozen foods must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times daily.	F 812		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 8, 2025

Administrator
Living Meadows At Luther - Madelia
503 Benzel Avenue Sw
Madelia, MN 56062

Re: State Nursing Home Licensing Orders
Event ID: 417X11

Dear Administrator:

The above facility was surveyed on March 24, 2025 through March 26, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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	00695	A. BUILDING: _____ B. WING _____	03/26/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 3/24/25 through 3/26/25, a 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 Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) services were provided according to the assessed need for 1 of 1 resident (R24) reviewed for positioning and mobility. Findings include: R24's facesheet printed 3/26/26, included diagnoses of heart failure, peripheral neuropathy (nerves located outside the brain and spinal cord are damaged causing weakness, numbness and pain), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), and osteoarthritis	2 895	Corrected	4/18/25

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LIVING MEADOWS AT LUTHER - MADELIA	503 BENZEL AVENUE SW MADELIA, MN 56062

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2 895	Continued From page 3 (degenerative disease with pain and stiffness) of multiple joints. R24's quarterly Minimum Data Set (MDS) assessment dated 2/26/26, indicated R24 was cognitively intact, had no behaviors including refusal of care and required assist of 1-2 staff for dressing and bed mobility and assist of 2 staff for toileting and transfers. The MDS included R24 has frequent pain which interferes with activities of daily living and rated pain at a level of 3 on scale of 1-10. R24's medications included opioid use, antidepressant, diuretic, hypoglycemic and antiplatet agent. R24's care plan last revised 2/26/25, indicated R24 had a self care deficit related to pain, decreased mobility, muscle weakness, and fatigue. Interventions included assist of 1-2 for dressing, and grooming. Toileting and transfer require assist of 2. Special directions included encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares (as tolerated/allowed by resident). May be completed when seated in wheelchair or when lying in bed. Report concerns/refusals to nurse. See therapy communication for additional information. On observation and interview 3/24/25 at 1:19 p.m., R24 stated "staff don't do exercises with me at all." On the wall in R24's room, ROM exercises for elbows and shoulders was posted. R24 indicated she was in therapy and they ordered these exercises but no one ever helps her do them. R24 stated she does go to restorative nursing services one to two times per week and they help her do other exercises. R24 added she isn't able to do the exercises by	2 895		

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2 895	Continued From page 4 herself as it is too painful to move her arms very far without some assistance from staff. R24's Rehab Communication form dated 1/6/25, by OT-C for nursing staff included "Please complete AAROM to bilateral upper extremities with AM and PM cares as patient tolerates either seated in wheelchair or lying in bed." Exercises to complete are attached. R24's Occupational Therapy Discharge Summary for dates of service 12/10/24 - 1/6/25, signed by occupational therapist (OT)-C included discharge to current skilled nurse facility with bilateral upper body AAROM twice a day by nursing to shoulder flexion/extension, shoulder abduction/adduction, shoulder horizontal abduction/adduction for 10 reps per motion. Prognosis is good with consistent staff follow-through. R24's treatment records for 1/8/25 thru 3/26/25, for encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares included 3 missed out of 77 opportunities with the initials by the nurse on duty that day completing the documentation. On interview 3/25/25 at 4:47 p.m., OT-C indicated R24 was in therapy until 1/6/25. OT-C stated R24 is compromised in her shoulders and elbows and needs ROM one to two times a day to maintain her motion. OT-C indicated AAROM is short for "active assistance range of motion" meaning staff should be assisting her. On interview 3/25/25 at 4:52 p.m., R24 indicated no one did ROM with her today but she did attend restorative therapy.	2 895		

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2 895	Continued From page 5 On interview 3/26/25 at 9:52 a.m., nursing assistant (NA)-D indicated NA's are responsible for doing ROM and R24 does her ROM exercises on her own. NA-D indicated they do not document if ROM is done or if resident refuses. On interview 3/26/25 at 9:54 a.m., NA-B indicated R24 does her ROM exercises on her own. NA-B added we will assist if she asks for help. NA-B indicated they don't document if ROM is completed or if resident refuses. On interview 3/26/25 at 9:58 a.m., registered nurse (RN)-A stated NA's are responsible to complete ROM but R24 can do her ROM exercises on her own. When asked if staff are completing the AAROM, RN-A indicated "I think she is completing them or I assume it is getting done when I document it is completed." On observation and interview 3/26/25 at 10:13 a.m., R24 was dressed and seated in her wheelchair in her room. R24 stated she needs staff to help her with her exercises and she is unable to do them without assistance. R24 demonstrated she could lift her arms approximately 2 inches without assistance and discomfort. R24 added they have done ROM on her once since January when it was ordered. R24 indicates staff never offer, never do the exercises with her when assisting her to get dressed and thinks staff "just don't care." On interview 3/26/25 at 10:44 a.m., the director of nursing (DON) stated if it is on the treatment record I would expect the nurse prior to documenting completion to check with the NA's to ensure it was offered and completed or check with the resident to ensure staff are completing it. The DON indicated she would expect the NA's to	2 895		

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2 895	Continued From page 6 be completing this with the resident per therapy recommendations. Facility Range of Motion Exercises policy dated 12/10/24, included: -Review the resident's care plan to assess for any special needs of the resident. -Be gentle with the resident and do not rush the procedure. -If the resident becomes weak, or complains of pain, cease the exercise and summon the staff/charge nurse. -Support the extremity at the joint as it is being exercised. -Move each joint through its range of motion three times unless otherwise instructed. -Move each joint gently, smoothly and slowly through it range of motion -Remember to stop an exercise before the point of pain. -Documentation should include the date and time performed, name and title of the individual who performed the procedure, the type of ROM exercise given, whether the exercise was active or passive, how long the exercise was conducted, if and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment, the reason why and the intervention taken. The signature and title of the person who is record this data. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to implementation of range of motion, could assure proper assessment and interventions are being implemented. The DON or designee could	2 895		

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2 895	Continued From page 7 re-educate staff on the policies and procedures. The DON or designee, could conduct audits to ensure compliance and report results to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R13) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include: R13's facesheet received 3/26/25, included diagnoses of Alzheimer's disease with early onset, osteoarthritis and spasticity (a condition with increased muscle tone, stiffness and involuntary muscle contractions). R13's quarterly (MDS) assessment dated 12/24/24, indicated R13 had severely impaired	2 905	CORRECTED	4/18/25

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2 905	Continued From page 8 cognition, and no behaviors. Activities of daily living (ADL's) included R13 uses a wheelchair and is dependent on staff for transfers, bed mobility, locomotion and for eating. R13 has no current skin issues but is at high risk for development of pressure ulcer. R13 has had no recent weight loss or gain and is incontinent of bowel and bladder. R13's Braden Scale for Predicting Pressure Sore Risk dated 12/24/24, had a score of 12 indicating R13 is at risk for skin breakdown. R13's care plan dated 4/10/24, indicated R13 has a potential for impaired skin integrity and is high risk for skin breakdown with interventions including: apply ointments/medications as ordered, use pressure reducing devices (mattress on her bed and cushion in her chair), assist with hygiene and general skin care. Avoid using hot water for cleaning. Reposition every two hours while in bed and offer fluids with position changes. Monitor skin daily with cares and report changes to charge nurse. Use moisturizer with cares and keep skin clean and dry. Use mechanical lift for transfers. Use incontinence pads and barrier cream to peri area as needed. Keep linen clean, dry and wrinkle free. Reposition every hour when up in chair. Increase protein in diet as appropriate and dietary consult as needed. A provider progress note dated 3/20/24, indicated R13 had a stage 2 pressure injury (open wound that affects both the top and bottom layers of the skin) of sacral region (large triangular bone at the base of the spine). The open area on left sacrum was 1.8 centimeter (cm) x 1 cm x 0.2 cm. Adjacent to this wound is a pinpoint open area. Drainage is minimal and green. Edges are well	2 905		

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2 905	Continued From page 9 defined and slightly macerated (skin is soft, wet or soggy to the touch and can delay wound healing). Right sacrum 1.2 cm x 0.2 cm x 0.1 cm think slit. No drainage and no odor. Will change treatment to cleansing with acetic acid 0.25%, skin prep to the intact periwound skin, applying calcium alginate AG (wound dressing that can absorb large amounts of exudate and has antimicrobial properties) to the wound bed and cover with a gentle adhesive foam dressing changing every other day or sooner if needed. Patient does rely on nursing staff for her repositioning and toileting needs. She does not have an air mattress on her bed at this time as she has a lip mattress. Staff are looking at options to apply an air overlay. Review of Skin Problems notes: 3/13/25: Right buttock skin is intact and within normal limits. Left buttock abrasion, scant drainage present, wound bed is 100% red, granulating tissue measuring 1.2 cm x 0.8 cm by 0.2 cm. Macerated tissue measuring 0.2 cm by 0.2 cm. Provider notified. 3/14/25: Abrasion to the left buttock continues to be open with a small 0.3 cm by 0.5 cm abrasion right below the current abrasion. 3/15/25: Abrasions x 2 to left buttock area. Area cleansed and dressing applied as ordered. Right buttock skin starting to slough, at this time is not open and cream was applied. 3/19/25: Dressing change to abraised [sic] tissue to left inner buttock completed. Small abraised [sic] tissue noted on 3/14/25 below current abraised [sic] site remains apparent. Also has abraised [sic] tissue to right inner buttock measuring approximately 0.2 cm x 0.2 cm. Physician notified of changes. 3/20/25: See provider note (above). 3/22/25: Left and right inner buttock/sacrum;	2 905		

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2 905	Continued From page 10 previous dressing soiled and removed to be changed. Moderate purulent drainage present on dressing. Wound appears light red, granulating tissue present. On observation 3/24/25 at 12:10 p.m., R13 was seated in her Broda (positioning chair) chair in the dining room. R13 was being assisted by staff with meal. On observation 3/25/25 at 8:44 a.m., R13 was seated in her Broda chair and was assisted from the dining room back to her room after breakfast by nursing assistant (NA)-A. At 8:45 a.m., R13 with assist from NA-A, and NA-B and a mechanical lift, was placed in her bed and positioned on her right side. NA-A and NA-B stated R13 is repositioned every two hours. NA-A and NA-B did not check R13's pad at this time. R13's bed did not have an air mattress or overlay present. Continuous observation including interviews, was started 3/25/25 at 8:45 a.m.: 9:15 a.m. R13 remains on her right side asleep. No staff into room. 9:43 a.m. R13 remains on her right side. No staff into room. 10:20 a.m. R13 remains in the same position with no staff entering the room. 10:46 a.m. R13 continues on her right side. No staff entered the room. 11:09 a.m. no change in position. Laundry staff entered room to put laundry away and activities staff changed the calendar in the room. 11:30 a.m. R13 continues on her right side. No staff into room. At 11:32 a.m. activities assistant (AA)-A looked into R13's room and stated R13 usually comes to sensory class at 11:00 a.m. but didn't come this morning.	2 905		

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2 905	Continued From page 11 11:38 a.m., license practical nurse (LPN)-A stated R13 was given a suppository this morning around 9:45 a.m. so they didn't get her up for sensory class. 11:54 a.m. no change in R13's position and no staff into the room. On observation and interview 3/25/25 at 12:00 p.m., NA-A and LPN-A entered the room. NA-A stated she was unsure if R13 had been repositioned since she assisted with putting her to bed as she isn't working R13's hallway. NA-A and LPN-A checked R13's pad. Stool was present and was smeared onto sacral dressing that was present on left sacral area. LPN-A after cleaning up stool, removed sacral dressing and stool was present under the dressing along with serosanguinous (bodily fluid with mixture of serum and blood) drainage. LPN-A cleansed wound with acetic acid 0.25% (antimicrobial properties) placed on a sterile 4x4 guaze pad, Xerofoam (sterile petrolatum-based gauze dressing used as a non-adherent dressing and promotes a moist wound environment) placed onto wound and covered with adhesive dressing. LPN-A measured wound on left sacral area which was 1.5 cm by 1.0 cm with a white spot present in the middle of the wound. LPN-A stated she was unsure what that was but the wound was improved from the last time she changed dressing. Right sacral area had no open area or abrasions present. LPN-A indicated the redness on both buttocks was from previous pressure sores that come and go. R13 with assist of mechanical lift and LPN-A and NA-A was placed in her chair and taken to dining room for lunch. R13's medication administration record (MAR) indicated (Dulcolax) Bisacodyl 10 mg suppository dose rectal daily as needed for constipation was	2 905		

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2 905	Continued From page 12 given 3/25/25 at 7:52 a.m. On interview 3/25/25 at 1:10 p.m., LPN-A indicated the suppository was given earlier than she had initially thought and R13 should been repositioned every 2 hours. On interview 3/25/25 at 1:59 p.m., NA-C stated she had not laid R13 down in her bed so was not sure when she needed to be repositioned. NA-C confirmed she had not repositioned R13 at all this morning and stated she was alerted to R13 not being repositioned and staff are now using a reposition sheet. On interview 3/26/25 at 10:48 a.m., the director of nursing (DON) stated she would expect staff to reposition R13 every 2 hours as indicated by the care plan. The DON indicated she has initiated a paper form for reminders for staff to reposition R13 as she had been made aware of R13 not getting repositioned yesterday. Facility Repositioning policy dated 11/19/24, included: - Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. -Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals -Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. -Positioning the resident on an existing pressure	2 905		

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2 905	Continued From page 13 ulcer should be avoided in most situations since it put additional pressure on tissue that is already compromised and may impeded healing. - A turning/repositioning scheduled includes a continuous consistent schedule for changing the residents position and realigning the body. -Residents who are in bed should be on at least an every 2 hour repositioning schedule or as determined by assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to repositioning of residents and educate staff. The DON or designee, could conduct audits to ensure compliance and report results to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dish machine	21134	CORRECTED	4/14/25

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21134	Continued From page 14 chemical sanitization solution was monitored to ensure dishes were properly sanitized. In addition, the facility failed to ensure temperatures were monitored in 1 of 2 kitchen freezers and 1 of 3 refrigerators (coolers). This had the potential to affect all 36 residents who resided in the facility. Findings include: Initial kitchen tour was conducted on 3/24/25 at 10:38 a.m., with cook (C-A) and dietary manager (DM)-A. Informed during the tour that the dish machine used chemicals for disinfection (low temperature dish machine). No chemical monitoring logs were visible in or around the dish machine area. Dietary aide (DA)-A was asked to provide the logs. The logs were in a binder on the other side of the kitchen. The paper logs indicated chemical monitoring was done very infrequently. A document titled Dish Machine Temperature & Sanitization Record indicated water temperature and sanitation solution was to be monitored daily with each of the three meals. Results were as follows: -- March 2025: chemical disinfectant had been tested 6 out of 69 opportunities. -- February 2025: 25 out of 84 opportunities -- January 2025: 26 out of 93 opportunities -- December 2024: 11 out of 93 opportunities -- November 2024: 1 out of 90 opportunities -- October 2024: 7 out of 90 opportunities -- September 2024: no documentation -- August 2024: no documentation -- July 2024: no documentation -- June 2024: 1 out of 90 opportunities -- May 2024: 6 out of 93 opportunities DA-A stated he was aware the disinfectant	21134		

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(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) COMPLETE DATE
21134	Continued From page 15 solution and temperature should be monitored and documented with each meal service, but did not have an explanation for why it had not been done. DM-A, who was new to the role, was unaware it had not been monitored. During an interview on 3/24/25 at 12:55 p.m., C-B was operating the dish machine. Using a chemical test strip, C-B tested the disinfectant solution in the dish machine, which registered at an acceptable level of 50 parts per million (PPM) and the gauge on the dish machine indicated an acceptable temperature of 128 degrees Fahrenheit (F). C-B admitted he knew the temperature and sanitizing solution should be monitored, but did not have a reason why it had not been documented. C-B acknowledged monitoring the chemical solution and temperature was important to kill bacteria on dishware. FREEZER & REFRIGERATOR TEMPERATURES During the initial kitchen tour on 3/24/25 at 10:41 a.m., C-A opened the silver 2-door freezer and couldn't find a thermometer. C-A immediately obtained a thermometer and added it to the freezer. The foods in the freezer were frozen solid to the touch. Temperature logs for the 2-door silver refrigerator and 2-door silver freezer were reviewed. The temperature log was titled Cook Temperature Sheet and on the bottom was a section titled Freezer and Cooler Temperatures. The last time any temperature was recorded was on 1/20/25. Temperatures at that time were in acceptable temperature ranges: Silver cooler: 36 degrees F Silver freezer: 2 degrees F During an interview on 3/25/25 at 11:11 a.m., C-A	21134		

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	00695	A. BUILDING: _____ B. WING _____	03/26/2025

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LIVING MEADOWS AT LUTHER - MADELIA	503 BENZEL AVENUE SW MADELIA, MN 56062

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21134	Continued From page 16 stated the morning and evening cooks were supposed to document temperatures of each refrigerator and freezer and record it. C-A stated, "We just weren't doing it." C-A acknowledged food needed to be maintained at correct temperatures to prevent spoiling and foodborne illness. During an interview on 3/25/25 at 11:30 a.m., DM-A acknowledged she had just started her role and had not been aware of the lack of monitoring and would correct it right away. On 3/26/25 at 12:15 p.m., the administrator was informed of kitchen findings. Facility Cleaning Dishes/Dish Machine policy dated 2021, indicated all dishware would be cleaned, rinsed and sanitized after each use. The dish machine would be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy indicated for low temperature dishwasher, wash temperature should be 120 degrees F., and 50 PPM hypochlorite (bleach). Facility Dish Machine Temperature Log policy dated 2021, indicated dishwashing staff would monitor and record dish machine temperatures to assure proper sanitizing of dishes. The director of food and nutrition services would post a log near the dish machine for the staff to document temperatures. Staff would record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition would spot check the log to assure temperatures were appropriate and staff were correctly monitoring dish machine temperatures. Facility Food Storage policy dated 2021, indicated	21134		

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	00695	A. BUILDING: _____ B. WING _____	03/26/2025

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21134	Continued From page 17 food would be stored at appropriate temperatures. Temperatures for refrigerators should be between 35 to 39 degrees F. Thermometers should be checked at least two times a day. Every refrigerator must be equipped with an internal thermometer. Frozen foods must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times daily. SUGGESTED METHOD OF CORRECTION: The dietary manager could develop and implement policy and procedure to ensure all staff have been educated, are following regulatory requirements, and are monitoring dish machine sanitation requirements, as well as refrigerator and freezer temperatures. Audits could be conducted to ensure compliance and results brought to the the facility's quality assurance committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134		

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING MEADOWS AT LUTHER - MADELIA	**503 BENZEL AVENUE SW** **MADELIA, MN 56062**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/25/2025. At the time of this survey, LIVING MEADOWS AT LUTHER 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 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. LIVING MEADOW AT LUTHER 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)	K 000		

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LIVING MEADOWS AT LUTHER - MADELIA	**503 BENZEL AVENUE SW** **MADELIA, MN 56062**

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K 000	Continued From page 2 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 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 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have a widespread impact on the residents within the facility.	K 291	1<291- Emergency Lighting annual 90-minute test. The annual test was completed by the Maintenance Department on April 9, 2025. During the inspection, 4 batteries were	4/14/25

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K 291	Continued From page 3 Findings include: 1. On 03/25/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation at the time of the survey that the facility could not provide documentation showing the emergency lights in the facility had been tested annually for 90 minutes within the last year. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 291	found to be faulty and were replaced on the same day with new batteries. Subsequent 90-minute tests will be scheduled in advance and placed on Google calendar with reminders set to complete on time each month of April. Internal audits will be completed to verify all annual tests/inspections are scheduled and completed. The EVS Director will ensure that all future 90-minute tests are completed on time and signed off each year.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		4/14/25

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K 321	Continued From page 4 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: 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, 19.3.2.1.3, and 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that Room 20 was being used to store combustible items and did not have a self-closing device on the door. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 321	1<321- Hazardous Areas-Enclosure Room 20 in the Oakwood hallway was found to be without auto closing spring hinges. To correct this issue, new hinges that are equipped with self-closing spring mechanisms were ordered and installed to satisfy the NFPA 101 requirements. Semi-annual inspections will be conducted for all spaces requiring self-closing mechanisms, with adjustments or replacements made as needed to maintain NFPA 101 compliance, Door closure inspections will be added to the Maintenance Departments preventative maintenance program, with documentation kept on file. The EVS Directorwill provide and track inspection documentation to ensure proper operation of enclosure doors. The hinges for room 20 were replaced by the Maintenance Department on April 7, 2025.	

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K 346	Continued From page 5	K 346		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2025 between 09:00 AM and 12:00 PM, it was revealed by review of available documentation that the fire alarm system out-of-service policy was incomplete and did not list the appropriate safety measures to follow. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 346	K346- Fire Alarm System-Out of Service Documentation The documentation for Living Meadows Life Safety Code, Section 5, subsection A "Notifications" erroneously listed out of service times for both Fire Alarm and Building Sprinklers for "more than 10 hours in a 24-hour period". This documentation has ben revised to specify "more than 4 hours in a 24-hour period" for Fire Alarms and retains the specification for "more than 10 hours in a 24-hour period" for Building Sprinklers. In order to prevent future errors in Life Safety documentation, a full review of the documentation will be made and updated as necessary. Additionally, records greater than 3 years old will be purged form the active record book and placed in a separate "Archive" folder for recall if needed. This will remove excess clutter in the main record book which should aid in overall organization of pertinent records for future review. The EVS Director will be responsible for	4/4/25

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K 346	Continued From page 6	K 346	maintaining, archiving, and updating main Life Safety record book and shall review annually for any required updates to policy and/or procedures. The current document was revised on April 4, 2025.	
K 372 SS=F	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 REQUIREMENT 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, and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/25/2025 between 9:00 and 12:00 PM, it was revealed by observation that there were unsealed penetrations in the smoke barrier located near the employee locker area.	K 372	K372-Smoke Barriers To meet NFPA 101 compliance for unsealed wall penetrations, the Maintenance Department will inspect areas in the employee locker area and the barrier above the fire doors connecting Pine and Rose hallways. Unsealed penetrations for cabling, plumbing and/or any other systems will be sealed with an NFPA approved sealant such as 3M's Fire Sealant caulk CP 25WB+, which is tested an rated for a minimum of 4 hours by UL 1479. Or 3M's Fire Barrier Sealant FB	4/14/25

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K 372	Continued From page 7 2. On 03/25/2025 between 9:00 and 12:00 PM, it was revealed by observation that there were unsealed penetrations in the smoke barrier between Pine and Rose. An interview with the Environmental Service Director verified these deficient findings at the time of discovery.	K 372	150+, which is also rated at 4 hours by ASTM E 1966(UL 2079). The EVS Director will also be inspecting other smoke barriers for unsealed penetrations and if discovered, they will be scheduled for proper sealing by the Maintenance Department utilizing the same products. Work on affected areas of concern will begin on or before May 1 , 2025 and Completion time for sealing penetrations will be no later than June 1, 2025.	