Electronically delivered
March 13, 2025

Administrator
Meeker Manor Rehabilitation Center
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: March 6, 2025

Dear Administrator:

On March 6, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 6, 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 6, 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3-3-25 to 3-6-25, 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 3-3-25 to 3-6-25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53616240C(MN00105086) H53618667C(MN00102048) H53618665C(MN00102867) H53618663C(MN00107465) H53618664C(MN00107879) H53618666C(MN00108458) H53618668C(MN00110448) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2025

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 000	Continued From page 1 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify presence of over the counter medications in resident room for 1 of 1 residents (R30) observed to have medications in their room. The medication lacked orders from the medical provider for use, as well as assessment for proper storage and and self administration of medication. In addition, the facility failed to ensure an assessment was completed to determine safe medication administration for 1 of 1 resident (R15) observed to self administer medication through a nebulizer (breathing treatment). Findings include: R30's quarterly Minimum Data Set (MDS) dated 12/9/24, indicated R30 was cognitively intact, and required assistance with performance of activities of daily living (ADL's). R30's diagnoses included anemia (a blood disorder in which the blood has a	F 554	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements	3/28/25

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F 554	Continued From page 2 reduced ability to carry oxygen), heart failure (a chronic condition where the blood doesn't pump blood effectively), hypertension (high blood pressure), end stage renal disease (a chronic kidney disease where the kidneys lose their ability to filter waste and excess fluids from the blood), venous insufficiency (a disease of the veins in the legs which causes blood to pool in the legs), diabetes mellitus (a group of diseases that affects how your body uses sugar), and depression. R30's March medication administration record (MAR), printed on 3/4/25 indicated R30 had prescriptions for the following medications: Medication for diabetic management: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Ozempic Subcutaneous Solution Peninjector (Semaglutide), NovoLOG Injection Solution (Insulin Aspart) Inject as per sliding scale: Vitamins and supplements: Multivitamin Oral Tablet (Multiple Vitamin) Cyanocobalamin Tablet 1000 MCG Folic Acid Oral Tablet 1 MG (Folic Acid) Thiamine HCl Oral Tablet 50 MG Vitamin D3 Tablet 5000 UNIT Zinc Sulfate Oral Capsule 50 MG Vitamin D3 Tablet (Cholecalciferol) Medications for heart conditions: Toprol XL Oral Tablet Extended Release 24 Hour Apixaban Oral Tablet During initial screening on 3/3/25, at 3:13 p.m., R30 was sitting in his wheelchair at his bedside. R30 had his bedside table near him. On the top of	F 554	under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F554 s/s D – Resident Self-Administration of Meds The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are assessed and determined to be safe for self-administration of medications. Residents who reside in the facility and can self-administer medications have the potential to be affected if this regulation is not met. R15 and R30 have been assessed for self-administration of medications and appropriate physician orders obtained, along with appropriate care plan revisions completed. All current residents that have been assessed and deemed able to self-administer medications have orders and are care planned. Policies and procedures were reviewed and revised as needed to ensure future instances are avoided. All necessary staff who have the responsibility and credentials to	

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F 554	Continued From page 3 the table, the following medications were noted in open site, in a plastic, shoe box size container: - Iron tablets: 65 mg tablets. There was one over the counter (OTC) bottle with 100 tablets on the label. R30 also indicated he had some in an unlabelled bottle, inside of another bottle with cash on the outside, so was not visible. R30 stated he took one tablet daily. Iron supplement is used for low blood iron, or anemia. - Berberine 800 mg/Milk Thistle 105 mg: R30 stated he was not using this supplement. Berberine is identified as being a supplement which may benefit heart conditions, blood sugar regulation, for bacteria, and also reduce swelling. - Keto and ACV Gummies 500 mg: R30 stated that he used one gummie every three to four days. This supplement is noted to be used for weight loss. R30 stated he has not used this product from this bottle and bottle was observed to be unopened. - Ashwaghanda 600 mg and Shiajit 300 mg supplement: This supplement was noted to be used to boost energy and decrease stress. R30 stated he has not used this product and product was observed to be unopened. - Sugar Defender 60 ml bottle with approximately 1/6th of the bottle used. This product is advertised as a supplement to balance blood sugar, control cravings, and promote weight loss. A review of medical record was completed and it was noted R30 had recently had lab work done to check his iron levels on 2/28/25, and the results of the iron was noted to be low at 44, with a	F 554	administer medications received education using Monarch Healthcare self-medication administration policy. -All residents (new and existing) that request to self-administer medication will be assessed after each request and prior to being able to self-administer medications -All MMHR nursing staff who have the responsibility and credentials to administer medications, received education using Monarch Healthcare self-medication administration policy. -MMHR staff, to include others who do not administer medications, received education using Monarch Healthcare Policy and Procedure on self-administration of medications; which includes, but is not limited to, what to do if a resident is found to have medications in their room. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party. Corrective action will be completed on or	

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F 554	Continued From page 4 normal range being 65-175 mcg/dL (metric unit of measurement). The medical record indicated the lab results were sent to the provider to review on 2/28/25. A review of the record lacked indication of physician follow up or subsequent orders for iron. R30's medical lacked indication of any orders for iron supplements. On 3/4/25 at 2:19 p.m., R30 was observed for wound care. Although wound care was provided by wound care nurse practitioner, clinical coordinator (CC)-B assisted with the process. While in room for wound care observation, R30 was noted to have medications as noted above, remained in place on top of bedside stand, readily viewed when in the room. On 3/5/25 at 9:37 a.m., CC-B, confirmed upon record review, lab work had been completed for R30 and had been faxed to the provider for review on 2/28/25. CC-B stated with a low iron level, as observed in lab work, she would anticipate a follow-up fax/order potentially for an iron supplement. CC-B stated resident was not currently on ferrous sulfate (iron) but received a multivitamin. CC-B was unaware of R30 keeping any medications in his room and at his bedside. CC-B was unaware of what the policy was for medications at bedside but would follow up on this. CC-B stated if R30 did not have orders to keep medications in his room then medications cannot be kept in his room. CC-B stated it was her expectation if staff members were to observe medications at bedside, they would report to her what was seen and she would then investigate, and follow up with the provider. CC-B stated medications found at bedside were to be removed until orders were obtained and the resident was assessed to be safe with self	F 554	before 3/28/25.	

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F 554	Continued From page 5 administration and storage. Following initial interview, a room visit was made with CC-B. At this time, CC-B observed medications at bedside. At this time, R30 informed CC-B he was taking iron tablets twice daily. CC-B informed resident he was not allowed to keep medications in his room until orders were obtained and assessments were completed. R30 would not allow medications to be removed. CC-B stated she would follow up with director of nursing (DON) and administrator to review situation and remove medications. On 3/6/25, at 11:50 a.m., DON stated it was her expectation residents would not have medications in the room unless they were ordered by the provider and resident had been assessed to safely self administer and store the medications. DON stated when found in the room without orders or assessment, the medications were to be removed until this was completed. DON expected the resident was educated as to why the medication needed to be removed until further assessment was done and orders obtained. The DON stated a self administration assessment for medication was completed with residents upon admission, reviewed annually, and updated as needed to assure the resident was cognitively and physically able to take meds. This assessment included the evaluation of the resident's vision, ability to open bottles, expressed understanding of medication, their use, dosing, and potential application of medications/powders/ointments ordered. R15's quarterly Minimum Data Set (MDS) dated 2/3/25, indicated R15 was cognitively intact, was	F 554		

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F 554	Continued From page 6	F 554		

independent with activities of daily living (ADL's). R15's diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia, shoulder pain, anxiety, depression, and respiratory failure.

R15's order summary report dated 2/1/25, directed staff to administer albuterol sulfate (medication to open airways, and treat air flow blockage) nebulization solution 1.25 milligrams(mg)/3 milliliters (ML) one vial via nebulizer two times daily. However R15's orders failed to include a provider order to self-administer albuterol sulfate.

Review of R15's electronic medical record (EMR) failed to include an assessment of R15's ability to safely administer nebulizer solution after facility staff set up medication. R15's care plan failed to identify residents ability to safely administer medications.

On 3/5/25 at 7:27 a.m., R15 was sitting in the wheelchair in doorway of room, licensed practical nurse (LPN)-B placed R15's albuterol medication in the reservoir of the mask, set the mask into holder on nebulizer machine and exited the room. LPN-B stated the nurses set up the medication, R15 did the breathing treatment on her own after breakfast.

When interviewed on 3/06/25 at 10:59 a.m., clinical manager (CM)-A confirmed R15 did not have an order to self-administer albuterol nor was there a self-administration of medication assessment completed when she had admitted to the facility in 2024, stating "It got missed".

When interviewed on 3/06/25 at 11:50 a.m.,

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F 554	Continued From page 7 director of nursing (DON) stated there was an assessment to be completed upon admission and as needed to see if they are able to cognitively and physically able to take meds. Open bottles, vision, understanding of meds, use, dosing, potential application, with an order in place for the process. This process is reviewed as needed, and annually. Facility policy Self-Administration of Medications dated 2/2024, indicated the interdisciplinary team (IDT) assessed each residents cognitive and physical abilities to determine whether self-administrating medications was safe and clinically appropriate, which would be documented in the medical record and care plan. The policy further identified self administered medications were stored in a safe and secure place, which was not accessible by other residents. If safe storage was not possible in the resident's room, the medications of resident's room, the medications were stored on a central medication cart or medication. Additionally, the policy stated any medications found at the bedside that are not authorized for self administration are turned over to the nurse in charge for return to the family or responsible party. The facility policy, Medication and Treatment Orders, last revised 2/2024, indicated drugs and biological orders must be recorded on the physician's orders sheet in the resident chart.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		3/28/25

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F 561	Continued From page 8 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to address resident requests for further therapy evaluation for 3 of 3 residents (R30, R1, and R212) reviewed for choices. Findings include: R30: R30's Quarterly Minimum Data set (MDS) dated	F 561	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute	

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F 561	Continued From page 9 12/9/24, indicated R30 was cognitively intact, and required assistance with performance of activities of daily living (ADL's). The MDS indicated there were no concerns regarding mood and behavior. The MDS identified R30 had intact cognition. R30's diagnoses included anemia (a blood disorder in which the blood has a reduced ability to carry oxygen), heart failure (a chronic condition where the blood doesn't pump blood effectively), hypertension (high blood pressure), end stage renal disease (a chronic kidney disease where the kidneys lose their ability to filter waste and excess fluids from the blood), venous insufficiency (a disease of the veins in the legs which causes blood to pool in the legs), diabetes mellitus (a group of diseases that affects how your body uses sugar), and depression. During initial interview on 3/3/25 at 2:42 p.m., R30 stated he was no longer allowed to use his electric wheelchair due to historic problems with use. R30 acknowledged he had "hit a resident who was in the middle of the hallway." R30 went on to state the other resident had some cognitive deficits. At that time he was also "low on iron" and wasn't right. R30 stated he had recently been seen by neurology and had received an order for the evaluation by therapy for use of an electric wheelchair. He had pursued follow up for this. At that time, R30 was provided with the previous notification dated 5/17/23. This document, titled Power Operated Vehicle and Scooter Policy, last revised 2/2012, had written indicators which identified R30 had a medical change, as well as "a lack of following therapy recommendations". The document also had a hand written notation which indicated R30 ran into another resident. R30 indicated the use of the electric wheelchair was important to him as he was unable to get into	F 561	an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F561 s/s D – Self-Determination The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident requests for therapy evaluation are addressed timely. All residents in the facility have the potential to be affected if this requirement is not met. R30, R1, and R212 have all been appropriately reviewed and assessed by therapy. Care plans for R30, R1, and R212 have all been reviewed and revised as necessary to reflect appropriate changes. All other residents were reviewed for non-compliance with no other issues	

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F 561	Continued From page 10 the bathroom with his current manual wheelchair. R30 stated although he was set up to perform oral hygiene, and to shave, it was difficult to do without a mirror and sink. R30 also stated his activity attendance had decreased when he had to propel his manual wheelchair, as it was physically taxing. R30 stated this impacted his participation in non-structured activities, wheeling up and down the halls, and socializing with other residents. Although R30 had received assistance with propelling his wheelchair, this was inconsistent related to staff availability. R30's care plan, revised on 6/19/24, indicated R30 is alert and oriented to person, place, and time. The care plan indicated R30 had experienced episodes of confusion/not making sense. The care plan directed staff to seek out occupational (OT) or speech therapy (SLP) to complete cognitive testing as needed. The care plan also identified R30 had an alteration in mobility related to lymphedema, autonomic neuropathy, lack of sensation to lower extremities, and weakness. The problem statement indicated on 10/6/23, R30 was noted to run lower extremities into nearby objects while in power wheelchair. The entry dated 2/2/24 indicated R30 was noted to run into another resident's wheelchair with power wheelchair and had not stopped. R30 was noted to be going an excessive speed. The problem statement, revised on 6/10/24, indicated "Power wheelchair removed indefinitely." The care plan directed staff to follow OT and physical therapy (PT) instructions for mobility function. The care plan identified R30 was transferred with a Hoyer (brand name of mechanical lift) and was non-ambulatory. The care plan indicated the primary locomotion was a manual wheelchair.	F 561	noted. All residents (new and existing) that self-determine their care will be appropriately assessed after each reasonable request. All MMHR staff received training to this requirement by utilizing resident rights. Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Administrator or Designee is responsible party. Corrective action will be completed on or before 3/28/25.	

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F 561	Continued From page 11 The care plan lacked any indication to direct staff to assist to propel him extended distances, or to and from activities, or meals. Additionally, the care plan lacked any perimeters to outline the requirements for, a formal re-evaluation for consideration of resumed use of the electric wheelchair. Upon review of medical record, it was noted on 2/26/25 R30 had been seen by neurology. The progress note identified R30 had a history of chronic neuropathic pain related to diabetes mellitus (DM)2 and metabolic syndrome. During R30's consult visit on 2/25/25, the provider indicated "Would like to do a power chair eval (evaluation), good cognition and good hand motion." The progress went on to to state the provider believed this would go well with PT training for safety for this, and should improve community access. On 3/4/25 at 2:39 p.m., clinical coordinator (CC)-B and wound care nurse practitioner (WCNP) were exiting R30's room. While in the room with R30, CC-B stated to R30 and surveyor an evaluation was set up for R30. As we continued to the nurse's station, CC-B stated the although order for evaluation had been received and discussed during the interdisciplinary team (IDT) meeting, which included therapy, administration, and clinical coordinators, the IDT does not feel this was a safe option for R30, therefore they would not be proceeding with the evaluation. CC-B stated this was due to his past history with the use of an electric wheelchair. CC-B stated she was unaware if there were any parameters or guiding points as to when this was to be reviewed and reassessed, and was unaware of any guidelines for reassessment.	F 561		

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F 561	Continued From page 12 CC-B stated although the IDT had decided for R30 not to be re-assessed, the decision had not been documented, relayed to the ordering provider, or relayed to R30. On 3/6/25, at 11:50 a.m. the director of nursing (DON) stated it was her expectation if an evaluation had been ordered, it would be completed. If the evaluation was determined to be not appropriate, it would be her expectation the staff would follow up in discussion with the provider who ordered the evaluation. R1: R1's quarterly MDS dated 1/6/25, identified R1 was cognitively intact. The MDS identified R1 was independent with eating, and required no assistance from staff. R1's was on a therapeutic diet, but lacked indication of need for mechanically altered diet. The MDS lacked any areas of dental concerns. R1's medical diagnoses included chronic obstructive pulmonary disease (COPD), anemia, hypertension, diabetes mellitus, and osteoarthritis. R1' care plan identified R1 had an alteration in dental care due to no teeth. The care plan identified R1 has full upper and lower dentures, however, states they are loose but do not interfere with talking or eating. This was last revised on 11/30/24. Additionally, the care plan identified R1 was a potential for altered nutritional status due to need for a therapeutic diet. The care plan directed staff R1 may have bread per speech therapy (ST). The care plan identified R1 was to receive large portions of protein. The care plan lacked any indicators R1 could not have peanut butter.	F 561		

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On 3/3/25 at 5:32 p.m., R1 expressed "The place is getting stupid. I have eaten peanut butter all my life and now they say I can't have it because of my diet." R1 stated he was told that peanut butter was "too sticky". R1 stated he was given no further rationale other than that and was told by dietary staff providing meals.

On 3/5/25 at 7:42 a.m., the culinary director (CD) reviewed R1's dietary card. This identified resident on consistent carbs for his diabetes. R1 was to be on a soft food diet, bite size. R1 was assessed by speech therapy and determined that it was authorized for him to have bread. CD stated R1 had a swallowing problem. As noted in the MDS, the resident is edentulous, however did have a set of dentures on his dresser which he preferred not to wear. CD stated she had verified the peanut butter dietary restrictions with the director of therapies (DOT) and was informed R1 was unable to have peanut butter, as this was related to the International Dysphagia Diet Standardization Initiative. CD stated R1 had historically received peanut butter and jelly sandwiches for a snack. CD stated she had been informed peanut butter restriction had been determined by ST. Documents titled Therapy to Nursing Communication Form dated 1/10/25, indicated R1 was on a dysphagia advanced diet, Level 6 diet and bite sized. A subsequent communication form on 1/23/25, indicated it was OK for R1 to have bread. A review of the ST assessment of 1/23/25, identified R1 may have bread.

On 3/5/25 at 9:59 a.m., CC-B was interviewed regarding the resident's limitation of peanut butter and stated she was unaware of the dietary

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restriction for resident regarding peanut butter.

On 3/5/25 at 11:08 a.m., ST stated she had been approached regarding R1's ability to have peanut butter. R1 stated when a resident who was on soft and bite sized diet, she would not recommend peanut butter. This was implemented as resident is edentulous and chose not to wear dentures. ST stated her last assessment was related to R1's ability to have bread and did not address R1's desire to have peanut butter. ST stated it was the facility policy to follow the IDDSI diet without exceptions.

On 3/6/25 at 10:03 a.m., CC-B stated she had received an order for speech evaluation which would determine if R1 was able to have peanut butter safely.

On 3/6/25 at 11:50 a.m., the director of nursing stated if R1 had historically eaten peanut butter without difficulty without dentures, it would be her expectation that an evaluation would be completed to determine if R1 was able to demonstrate the ability to do so safely. DON stated it was her expectation, if R1 was not to have peanut butter due to safety concerns, this would be known by the CC-B, nursing staff, and dietary staff and implemented accordingly. If R1 was deemed safe to have peanut butter, an appropriate dietary order would be sought and put into place, and staff would follow that order.

R212:

R212's quarterly MDS assessment, dated 1/28/25, indicated R212 was cognitively intact. R212 was identified as requiring use of a

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wheelchair and receives assist with all aspects of mobility. R212's medical diagnoses included malignant neoplasm (a type of abnormal and excessive growth of tissue) of unspecified part of the right bronchus or lung, cancer, anemia, coronary artery disease (type of heart disease which affects the main blood vessels that supply blood to the heart, called the coronary arteries), hypertension, malnutrition, anxiety disorder, depression, and pain related to neoplasm.

On 3/3/25 at 7:05 p.m., R212 stated she had previously been able to use a walker for transfer and now requires the use of an EZ stand (a mechanical lift used to assist resident in an upright standing position, to transfer between bed, wheelchair, and bathroom). R212 stated she actively performed leg exercises three times a day, with twenty repetitions to maintain strength and mobility. R212 demonstrated this by raising leg even to her hip flexure, while sitting in a chair. R212 stated she had expressed this before to staff, however, she had received no further information regarding this.

R212's care plan initiated on 8/15/24, indicated R212 had alteration in mobility related to malignant neoplasm of ovary, anxiety, malignant neoplasm of right lung, and weakness. The care plan directed staff to provide assist with bed mobility, to boost up in bed, and to get feet into, and out of the bed. Staff were directed to assist with locomotion of her wheelchair, provide assist of one with movement in bed, and in/out of bed with assist of two with the use of an EZ stand for transfer.

A review of narrative notes of 2/6/25, written by previous administrator, indicated resident stated

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"What I really want is to see a physical therapist." In this narrative, the former administrator explained hospice residents typically do not receive therapy services. The narrative note identified R212 replied that she was aware of this. The narrative note went on to indicate the prior administrator would look into this, and would ask CC-B to assist. A review of further documentation reflected no further follow up was completed.

On 3/4/25 at 4:09 p.m., CC-B stated she was unaware of this request of R212 for physical therapy evaluation. CC-B stated she would follow up with physical therapy regarding a possible screen or assessment.

On 3/5/25 at 8:19 a.m., director of nursing stated R212 had been assessed for mobility upon her admission to the facility. DON stated R212 had a subsequent evaluation 9/26/24 following a fall. R212 had been weak with a bathroom transfer, and the recommendation was for the resident to use EZ stand. The narrative note from physical therapy indicated "Resident is on hospice and not appropriate for therapy. " DON stated she was unsure as to why the request on 2/6/25 was not acted upon. DON stated she was unaware of the request.

Upon subsequent interview on 3/6/25 at 11:50 a.m., DON stated she and the clinical coordinators reviewed the narrative notes on a daily basis. When requests are made, the expectation was when clinical coordinator became aware, they would follow through. Additionally, DON stated if staff were referring a request to another person, this should be done via email for tracking purposes, as well

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F 561	Continued From page 17 acknowledgement of the concern. The facility policy, Resident Rights Policy, dated 1/2024, identified that is the practice of the facility to uphold the rights of all residents. The policy further states the residents of the facility will access to the information regarding the Combined Federal and State Bill of Rights in writing via the electronic admissions process. The residents will acknowledge the receipt of the documents. The policy further states the resident can stated a physical copy upon admission, or at any time by requesting a copy from social services, and identified a copy of the bill of rights was posted in the facility. The policy lacked any information or direction how to assure the actual rights were implemented on behalf of the resident, or of what the actual rights were.	F 561		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		3/28/25

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F 732	Continued From page 18 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the current daily nurse staff posting. This had the potential to affect all 50 current residents, their families and visitors. Findings include: During observation on 3/3/25 at approximately 11:00 a.m., the facility nurse staff posting was posted on the wall next to the office receptionist desk at approximately three feet from the floor. The posting included the date, direct care nursing staff shifts, numbers, total hours worked, and daily census. The nurse staff posting document was dated 2/27/25. The document behind the 2/27/25 document was dated 2/26/25. The staff posting documents for 2/27/25, 2/28/25, 3/1/25,	F 732	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to	

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3/2/25, and 3/3/25 were lacking.

On 3/5/25 at 1:03 p.m., staffing coordinator (SC) stated it was her responsibility to post the staff posting on Mondays through Friday. SC stated no one posted the information on the weekends. SC stated she updated the posting on Monday upon her return. SC stated the information posted on the staff posting was important to allow the staff, residents, visitors, and family members to see the hours staffed at the facility.

On 3/6/24 at 7:55 a.m., the director of nursing (DON) stated the staff posting contains all the staff working as well as the hours worked. This was important for continuity of care and to inform others of the staffing present and hours worked, and to assure there are enough staff available to provide care for the census of residents in the nursing home. The DON stated this information was important for the residents and visitors. The DON stated it was the responsibility of the scheduler to place the staff posting during the week, and during the weekend hours, it is delegated to the designated charge nurse.

A review of the facility policy, titled The Nursing Hours Posting policy, dated 10/22/2022, identified it was the policy of the facility to post nursing staffing data on a daily basis at the beginning of each shift, to include facility name, the current date, the total number and actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care (registered nurses, licensed practical nurses, and certified nursing assistants), and resident census.

F 732

the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F732 s/s C - Posted Nurse Staffing Information

The process for satisfying this requirement has been reviewed and revised as needed, to ensure the actual hours and number of each direct nursing staff are posted per each shift.

This had the potential to affect all residents, staff, and visitors who wished to view the information.

No changes or revisions to the Monarch Healthcare Management Policy and Procedure were required.

In accordance with Monarch Healthcare Management Policy and Procedure, the actual hours and number of each member of staff have been updated as necessary, to reflect current information.

All MMHR staff, including the staffing coordinator, received training on the requirement to post nursing staff information utilizing Monarch Healthcare Management policy and procedure on Nursing Hours Posting.

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MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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F 732	Continued From page 20	F 732	Monitoring to assure compliance with this requirement will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Administrator or designee is responsible party. Corrective action will be completed on or before 3/28/25.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the	F 791		3/28/25

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F 791	Continued From page 21 dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the oral health needs for 1 of 1 resident (R5) reviewed for routine dental services. R5's quarterly Minimum Data Set (MDS) dated 1/21/25, identified an admission date of 10/22/24, R5 had intact cognition, diagnoses of heart failure, chronic kidney disease and limitation of activities of daily living due to disability. R5's oral/dental evaluation dated 1/21/25, identified R5's teeth were observed to have plaque or debris in localized areas between teeth with several teeth missing and staff would assist	F 791	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	

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F 791

Continued From page 22
with setting up dental appointments and transportation.

During observation on 3/3/25 at 2:56 p.m., R5's teeth had a significant amount of built up white/grey debris on her front teeth and several missing teeth on her upper left side. R5 denied pain or difficulty with eating. R5 stated she could brush her own teeth with staff assistance for set up of her toothbrush and toothpaste at the sink. R5 stated she didn't remember when she last had a dental check-up but thought she was due for one as it had "been years".

When interviewed on 3/5/25 at 8:34 a.m., nursing assistant (NA)-E stated staff assist R5 with set-up at her bathroom sink with her toothbrush and toothpaste and could normally brush her own teeth. NA-E stated the facility nurses were responsible for setting up resident dental appointments when needed.

When interviewed on 3/5/25 at 8:39 a.m., clinical manager (CM)-A stated the facility procedure for offering resident assistance with routine dental appointments and transportation occured with the completion of the initial admission assessments and MDS. CM-A confirmed this should have been done for R5 with her admission in October of 2024 but was missed.

When interviewed on 3/5/25 at 12:04 p.m., the director of nursing (DON) stated the facility procedure and expectation was for residents to be assessed for oral/dental needs and assisted with making needed appoints upon admission. The DON stated staff should confirm the date of the last dental appointment and determine if the resident needed or wanted assistance with

F 791

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F791 s/s D – Routine / Emergency Dental Services

The process to satisfy this requirement has been reviewed and revised as needed to ensure oral health needs of residents are reviewed for dental services

All residents in the facility have the potential to be affected if this requirement is not met.

All residents were reviewed for dental and oral needs.

R5 has discharged from the facility

To avoid future non-compliance, the facility has coordinated with a dental provider to provide on-site services to the residents.

All MMHR staff received education utilizing Monarch Healthcare Policy on title: Dental Services.

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F 791	Continued From page 23 setting up an appointment and transportation. The DON confirmed this was missed for R5. The facility policy Dental Services dated December 2013. Identified Routine and emergency dental services are available to meet resident's oral health need in accordance with the resident assessment and plan of care and personnel would be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.	F 791	Monitoring to assure compliance with this requirement will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party. Corrective action will be completed on or before 3/28/25.	
F 812 SS=E	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	F 812		3/28/25

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F 812	Continued From page 24 by: Based on observation, interview and document review, the facility failed to consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures for 1 of 1 dishwasher observed. The facility also failed to consistently date fresh and frozen items at the time they are opened, or placed into a container, and failed to remove items which were beyond the acceptable date of use from the refrigerator. The facility failed to consistently verify temperatures were within the desired range in the refrigerators and freezers to assure food integrity. In addition, food temperature monitoring lacked consistency of completion following food preparation and prior to serving. This had the potential to affect all 50 current residents, as well as staff and visitors, who ate food served from the kitchen. Findings include: Dishwashing Temperature Monitoring: On 3/3/25 at 12:08 p.m., dietary aide (DA)-A was observed as she was finishing up in the dish room and was transitioning to meal service. DA-A stated the desired temperature was 150 degrees Fahrenheit for washing dishes. If the temperature was not at 150 degrees, the dishwasher racks needed to be run through again until the temperature was up to 150 degrees Fahrenheit (F). DA-A stated the rinse temperature was to be at 160 degrees F. DA-A stated if the temperature was not at 160, the rinse racks needed to be run through again until the rinse temperature reached the 160 degrees F. On 3/3/25 at 6:27 p.m., DA-B was observed to be	F 812	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F812 s/s E – Food Procurement, Store/Prepare/Serve - Sanitary The process for satisfying this requirement has been reviewed and revised as needed, to ensure dishwasher and refrigerator/freezer temperatures are appropriately tracked and food is appropriately managed by date.	

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F 812	Continued From page 25 washing dishes. When asked what the temperature checks were prior to starting the dishwashing process, DA-B stated she had not yet checked the temperature, as she had been taught to check the temperatures at the end of the dishwashing process. DA-B stated monitoring the dishwasher temperature was important as the temperature needed to be high enough to kill bacteria and germs. DA-B stated this was important because if the temperature was not high enough, and the germs weren't yours, it could make people sick. A review was completed of the March dishwashing temperature logs. Upon review of the dishwashing log, it was noted there was one shift at noon on 3/2/25 when temperatures were not logged, in addition two evenings (3/1/25 and 3/2/25) were not logged. On 3/2/25, it was noted with the morning wash cycle the temperature was only at 147 degrees F, versus the desired 150 F. All other temperatures recorded were within the desired range. The directions on the bottom of the temperature log for March indicated staff were to report if the wash temperature was less than 150 degrees F, and if rinse temperature was less than 160 degrees F. A subsequent copy received of the March Dishwashing Record High Temperature log was amended to reflect the rinse cycle was to be at 180 degrees F. An untitled document dated 3/3/25 at 7:15 p.m., from the administrator indicated she had completed a review of the dishwashing process to assess its temperature performance on this date. The note indicated: "During the wash cycle, I observed the temperature ranged from 135 to 145 degrees F. The document additionally indicated "In the rinse cycle, the temperature	F 812	All residents residing in the facility have the potential to be affected if this requirement is not met. The policy and procedures necessary to meet this requirement were reviewed and revised as needed to ensure food is appropriately labeled and staff are aware of the requirement to track dishwasher and refrigerator temperatures. No changes or revisions to the Monarch Healthcare Management Policy and Procedure were required. The Culinary Director is responsible for oversight of this requirement. All MMHR staff have been initiated utilizing Monarch Healthcare Management policy and procedures on dishwashing machine use, food receiving and storage, refrigerators and freezers, and food temperatures. Audits will review dishwasher temperatures, refrigerator/freezer temperatures, and ensuring food is appropriately managed by date. Monitoring to assure compliance with this requirement will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.	

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F 812	Continued From page 26	F 812		

increased to a range of 180 degrees F to 190 degrees F."

The administrator was unaware of the desired range for wash temperature.

A review for the February temperature log was unable to be completed as the temperature log was not located.

A review of the January Dishwashing Record High Temperature log was completed from 1/1/25 through 1/31/25. The log lacked documentation as follows:
1/1/25-1/7/25: Morning, Noon, and Evening meals.
1/8/25: Morning and Noon.
1/9/25 through 1/11/25: Morning, Noon, and Evening meals.
1/12/25 through 1/14/25: Evening meal.
1/15/25 and 1/16/25: Noon meal.
1/17/25: Evening meal.
1/18/25: Morning, Noon, and Evening meals.
1/19/25 through 1/21/25, as well as 1/23/25: Evening meal.
1/24/25: Morning, Noon, and Evening meals.
1/25/25: Morning and Noon meals.
1/26/25 and 1/27/25: Evening meal.
1/28/25: Morning, Noon and Evening meal.
1/29/25 through 1/31/25: Evening meal.

Upon review of the temperatures logged for January, the following was noted:

During the morning wash cycle, of the 16 entries made, only eight met the temperature requirement of 150 degrees F or greater. A review of the 16 rinse cycles recorded, only four of the 16 met the required temperature level

Culinary Director or designee is responsible party.

Corrective action will be completed on or before 3/28/25.

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identified on the document as 160 degrees F.

During the noon wash cycle, there were 14 entries made. Of the 14 entries made, 11 entries were 150 degrees F or greater. A review of the 14 entries for the rinse cycle, there were four of 14 entries with a rinse temp of 160 degrees F or greater. The remaining 10 entries did not meet the required temperature.

A review of the evening wash cycles identified there were four entries completed out of 31 opportunities. Of the four entries completed, there were three entries which met the required wash temperature of 150 degrees F or greater. The evening rinse temperature documentation indicated there were three of four entries which were 160 degrees F or greater.

On 3/3/25 at 12:19 p.m., the dishwasher logs were reviewed with culinary director (CD). CD stated if the dishwasher was not up to temperature, the dishes were not properly cleaned. CD went on to say there would be the potential for bacteria presence, which could make people sick. CD stated she was unaware of any outbreaks of Norovirus, or other patterns of illness. At this time, a review was completed with CD regarding the absence of temperature logging in January. CD stated it was important to assure the dishwasher was at the right temperature and this was done with routine monitoring. CD was unable to locate the dishwasher temperature log for February.

On 3/5/25 at 7:28 a.m., CD stated upon review of the CMA-180 dishwasher company manual, she became aware the required rinse temperature is to be at 180 degrees F or hotter to meet the

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F 812	Continued From page 28 manufacturer recommendations. Previously, the staff had been instructed to have the rinse cycle at 160 degrees F. CD stated staff education has been completed for this, and log has been updated to reflect the proper temperature for the rinse cycle. A review of the company manual for the CMA-180 dishwasher was completed. The CMA-180 dishwasher was a high temp dishwasher. The manual outlined the required cycle temperatures as being 155-160 degrees F for the wash cycle, and 180-195 degrees F for the rinse cycle. The manual directed staff to check the machine operating temperatures and adjust as needed. The manual went on to direct staff: After the machine has warmed up for five to ten minutes, observe the wash and rinse cycles. The wash temperature must be at 155 degrees F minimum. The rinse temperature must be at 180 degrees F minimum. The undated facility policy, Dishwashing Machine Use, identified staff required to operate the dishwashing machine were to be trained in all steps of dishwashing machine process by the supervisor or designee proficient in all aspects of proper use and sanitation. The facility policy identified the wash solution temperatures were to be at 150 degrees F. The policy further directed the hot water sanitation rinse may not be more than 194 degree F, and no less than 180 degrees F. The policy directed staff to check temperatures with each dishwashing machine cycle and record the results in a facility approved log. The facility policy directed staff to monitor the gauge frequently during the dishwashing machine cycle and report to supervisor if it was below the desired temperatures.	F 812		

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F 812 Continued From page 29 F 812

Food Storage:

On 3/03/25 at 11:32 a.m., during the initial tour with CD, a tour was completed with the walk-in cooler and freezer. Upon entering the walk-in cooler, there was a tray of 30 containers of covered gelatin, dated 2/21/25. CD stated food was to be used within seven days of preparation, and this should not be used. An undated container, which was larger than a gallon, was noted to contain spinach. CD stated any undated foods would need to be disposed of.

Upon entering the walk-in freezer, there was a large 20 bound bag of ice, which had clumped together, placed on the floor of the freezer. CD stated this had been used when the ice machine was not working. On the floor, next to the ice, was a box of blackened bananas. Upon viewing with CD, it was noted there were approximately five to six bunches of bananas, with five to six bananas per bunch. CD stated she had not gotten to making banana bread. While in the freezer, a ten-pound box of stew meat was noted to be opened and undated, with approximately 50% remaining. CD stated that was from the previous Friday when they had beef stew. On an upper freezer shelf, there were three packages of hot dog buns, containing 8 buns each. There were crystals within the bag. Although the bags were unopened, there was no date on the bag from the distributor. CD stated it had been a while since they served hot dogs and removed the bags of buns. Additionally in the freezer, there was an undated three-gallon container with approximately 1/3 of the container left, of sherbet. In addition to the sherbet, there was a second undated three-gallon container of ice cream with

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approximately 1/2 of the container remaining. There were no crystals noted on either the ice cream or sherbet.

On 3/3/25 at 11:40 a.m., the reach in refrigerator was observed and was noted to have one undated salad with approximately four other salads. CD stated these are prepared for daily use. In addition, there was an undated gallon container of shredded cheese, approximately 1/4 to 1/2 full. Upon review of the reach in freezer, there was an undated open sleeve of French toast with six slices present. In addition, there was also an undated sleeve of waffles which had four waffles remaining.

An undated facility policy, Food Receiving and Storage, identified food shall be received and stored in a manner that complies with safe food handling processes. The policy identified all foods stored in the refrigerator or freezer were to be covered, labeled and dated (use by date). Although the policy identified food in designated dry storage areas shall be kept at least 18 inches off the floor, it lacked direction for storage of food in the walk-in cooler or freezers.

Temperature Logs Freezer/Refrigerators:

On 3/03/25 at 11:27 a.m., an initial kitchen tour was completed with the culinary director (CD). With the tour, a review was completed of the walk-in cooler and freezer, as well as the reach in cooler and freezer. A review was completed of the temperature logs for both the freezer and refrigerators for March. The temperatures for the refrigerator ranged between 36-40 degrees F, and the freezer temperatures ranged from -1 to -3 F. Morning Cook (MC)-A stated the temperatures

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were checked daily, prior to food prep. All temperatures recorded for March were within the desired range.

A review of the February log was completed for the dates 2/1/25 through 2/28/25.
The log lacked documentation on the following dates: 2/1/25, 2/5/25, 2/8/25, 2/14/25, 2/15/25, 2/18/25, 2/19/25, 2/22/25, 2/23/25, and 2/27/25. Of the 28 possible entries, there were 10 entries lacking. It was identified with the temperature checks that were performed that all readings were within the desired ranges.

A review of the January log was completed for the dates of 1/1/25 through 1/31/25.
The log lacked documentation on the following dates: 1/1/25 (Documentation lacking for the walk-in cooler and freezer), 1/2/25, 1/11/25, 1/12/25, 1/20/25, 1/21/25, 1/22/25, 1/25/25, and 1/26/25. All temperatures except for two were within the desired range. On 1/1/25, the reach in refrigerator was at 41 degrees F, and on 1/28/25, the reach refrigerator was at 42 degrees F. There were no subsequent elevations of temperatures with the walk-in refrigerator.

An undated facility policy, titled Refrigerators and Freezers, identified the acceptable temperatures for refrigerators were 35 to 40 degrees F and less than 0 degrees F for freezers. The policy indicated designated employees were to check and record refrigerator temperatures daily with the first opening and at first closing in the evening.

Food Temperature Monitoring:

On 3/3/25 at 11:31 a.m., meal preparation was

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observed with MC-A, with appropriate temperature checks performed. A review of temperature log was completed with findings as noted below:

A review of the March temperatures were noted to be consistently completed for breakfast and lunch and were noted to be within the desired range. The temperature log for the evening meal was completed on only one occasion out of three opportunities, which was within the desired range.

A review of the February food temperature log identified the breakfast log was lacking 10 entries out of 28 days: 2/1/25, 2/5/25, 2/9/25, 2/14/25, 2/15/25, 2/18/25, 2/19/25, 2/22/25, 2/23/25, and 2/27/25.

A review of the February food temperature log for the noon meal indicated there were 11 entries missing out of 28 days:2/1/25, 2/5/25, 2/8/25, 2/9/25, 2/14/25, 2/15/25, 2/18/25, 2/19/25, 2/22/25, 2/23/25 and 2/27/25.

A review of the February food temperature log for the evening meal indicated there were 22 entries missing out of 28 days: 2/1/25, 2/3/25, 2/4/25, 2/6/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/14/25, 2/15/25, 2/16/25, 2/1/9/25, 2/20/25, 2/21/25, 2/22/25, 2/23/25, 2/24/25, 2/25/25, 2/26/25, 2/27/25 and 2/28/25.

A review of the February meal temperature log identified it lacked documentation for 43 of 84 meals served.

A review of the January food temperature log identified the breakfast log was lacking 10 entries out of 31:1/2/25, 1/4/25, 1/11/25,

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1/12/25,1/20/25,1/21/25, 1/22/25, 1/25/25, 1/26/25, and 1/28/25.

A review of the January food temperature log for the noon meal indicated there were 12 entries missing out of 31 days: 1/1/25, 1/2/25, 1/4/25, 1/11/25, 1/12/25,1/18/25, 1/20/25, 1/21/25, 1/22/25, 1/25/25, 1/26/25, and 1/28/25.

A review of the January food temperature log for the evening meal indicated there were 30 entries missing out 31. The only day there was an entry in the temperature log was on 1/3/25.

The meal temperature log lacked documentation for 52 of 93 meals served. The entries present were within the desired temperature range.

A review of the Resident Council Meeting Minutes was completed. On 1/10/25, the Resident Council Meeting Minutes, reflected the room trays were cold in the evenings. The follow up on this concern was delegated to CD.

On 3/5/25, at 7:28 a.m. a review was completed with CD regarding the temperature monitoring of meals, especially for the evening meals. CD stated upon gathering documents for review, she noted there were gaps in monitoring, especially for the evening meals. CD stated she had been alerted of the concerns with cold food addressed by Resident Council. CD feels this was related to a delay in serving the trays once they go out to the floor. CD stated she had begun to track tray delivery time to help determine the cause of cold room trays but had only one tracking sheet available for 2/17/25 to 2/26/25. CD stated it was important to ensure food was at the proper temperature to prevent food borne illness related

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F 812	Continued From page 34 to bacteria. If the food is at the correct temperature, it assures it is cooked. In addition to food safety, proper temperature increases the joy of the food, stating "Nobody wants cold food." The facility policy, dated April of 2019, identified the "danger zone" for food temperatures was between 41 degrees F and 135 degrees F. The policies goes on to identify this temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. The policy outlined the parameters of temperatures to be maintained for food safety and directed staff to maintain proper hot and cold temperatures during food service.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		3/28/25

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conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 36 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain sanitary conditions for mechanical lifts for 6 of 6 residents (R35, R47, R9, R27, R3, R2) who used a mechanical lift for transfers. This had the potential to affect other residents who used a mechanical lift for transfers. In addition, the facility failed to ensure hand hygiene while providing personal cares to prevent the spread of infections for 2 of 2 residents (R3, R9) observed during personal cares. Findings include: Mechanical lifts: During an observation on 3/4/25 at 10:19 a.m., nursing assistant (NA)-D wheeled R35 into his room and brought in the Hoyer lift (a mechanical lift to lift a person who is non-weight bearing for transfers). Clinical coordinator (CC)-A went to R35's room and applied a gown and gloves as R25 was on enhanced barrier precautions (Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). NA-D also applied a gown and gloves. NA-D and CC-A transferred R35 to the bed with use of hoyer lift. Once the transfer was complete CC-A took off the gloves and gown, washed her hands pushed the Hoyer lift into the hallway, and walked away without sanitizing the Hoyer lift. The	F 880	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F880 s/s D □ Infection prevention and control The process for satisfying this	

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F 880	Continued From page 37 Hoyer lift was brought into R9's room at 11:44 a.m., RN-A and NA-D assisted R9 from her bed to her wheelchair. RN-A removed the hoyer from the room placed it in the hallway and walked away without sanitizing the machine. During an observation on 3/4/25 at 11:00 a.m., NA-A brought a mechanical standing lift into R3's room. NA-A applied the mechanical sling to R3. NA-A and NA-C assisted R3 to a standing position and transferred R3 to the bathroom. When R3 was finished using the bathroom, NA-C and NA-A assisted R3 to her recliner. NA-A pushed the mechanical standing lift into the hallway and walked away without sanitizing the machine. During an observation on 3/4/25 at 1:23 p.m., NA-C and NA-B brought the Hoyer lift out of R9's room and took the Hoyer down the hallway to R47's room. NA-C and NA-B applied gowns and gloves as R47 was in enhanced barrier precautions, NA-C then pushed the Hoyer to lift into R47's room. During an observation on 3/5/25 at 8:39 a.m., NA-D brought the mechanical standing lift into room R27's room applied gloves, and hooked R27 up to the mechanical standing lift. The activity director (AD) entered the room and assisted with the transfer. Once done with the transfer AD took the mechanical standing lift and placed it in the hallway. AD then walked away without sanitizing the mechanical standing lift. During an observation on 3/5/25 at 8:40 a.m., the Hoyer lift was in R9's doorway, NA-D pushed the lift into the room. NA-D provided morning care and attached R9 to the Hoyer lift. NA-A came into	F 880	requirement has been reviewed and revised as needed, to ensure necessary staff use proper hand hygiene during nursing cares and sanitize mechanical lifts between use with residents Residents residing in the facility who utilize a lift for transfers and/or receive nursing care from staff have the potential to be affected. All necessary staff have received re-education on appropriate hand hygiene practice(s) and sanitization of mechanical lifts. Hand hygiene and mechanical lift sanitization was completed using Monarch Healthcare Management Policy and Procedure Monitoring to assure compliance with proper hand hygiene during nursing cares and sanitizing mechanical lifts between use will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. Director of Nursing or designee is responsible party. Corrective action will be completed on or before 3/28/25.	

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the room and assisted with the transfer. After the transfer was complete NA-A took the Hoyer lift out of the room placed it in the hallway and walked away without sanitizing the Hoyer lift. At 10:19 a.m., NA-D took the Hoyer lift to R2's room.

During an observation on 3/4/25 at 10:42 a.m., NA-A retrieved the mechanical standing lift from the hallway brought it into R3's room. NA-A applied a lift sling around R3. NA-C lifted R3 from the recliner transferred R3 into the bathroom and lowered R3 onto the toilet. When R3 said she was finished on the toilet, NA-C lifted R3 from the toilet. NA-A took a wet wipe and provided perineal care. NA-A discarded the wet wipe into the garbage and pulled up R3's brief and pants. NA-A then removed their gloves pushed R3 back to her recliner and lowered her into her recliner. NA-A placed the mechanical standing lift into the hallway and walked away without sanitizing her hands or the mechanical standing lift.

During an interview on 3/4/25 at 11:07 a.m., NA-A indicated she believed the night shift cleans the mechanical standing lifts and Hoyer lifts but was unsure and said she would find out. NA-A confirmed she did not sanitize the mechanical standing lift after use in R3's room. During a follow-up interview on 3/5/25 at 10:50 a.m., NA-A indicated mechanical standing lifts and Hoyer lifts were supposed to be washed with soap and water on overnights, but could not verify as NA-A does not work the overnight shift. NA-A verified she did not sanitize the Hoyer lift after use in R9's room.

During an interview on 3/5/25 at 10:55 a.m., NA-D indicated mechanical standing lifts and Hoyer lifts should be sanitized when coming out

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of a resident's room when the resident is on enhanced barrier precautions and once a day. NA-D indicated she typically tries to sanitize the mechanical standing lifts and Hoyer lifts when she has time. NA-D confirmed she did not sanitized Hoyer lift between R9's and R2's rooms.

During an interview on 3/5/25 at 2:31 p.m., activities director (AD) indicated mechanical lifts should be sanitized between residents. AD confirmed she did not sanitize the mechanical standing lift after assisting the NA-D with transferring R27. The activities director's expectation would be for nursing assistants to clean the mechanical lifts unless they requested AD to clean the machine.

During an interview on 3/5/25 at 11:07 a.m., CC was unable to verify how often the medical standing lifts and Hoyer lifts should be cleaned and or sanitized. CC confirmed she did not sanitize the Hoyer lift after use with R35.

During an interview on 3/5/25 at 11:28 a.m., RN-A indicated mechanical standing lifts and Hoyer lifts should be cleaned between residents. RN-A verified she did not clean the mechanical standing lift or Hoyer lift as she was passing medications. Her expectation would be for the nursing assistant to clean the lifts unless the nursing assistant requested help.

During an interview on 3/5/25 at 12:14 p.m., director of nursing (DON) indicated the mechanical standing lifts and Hoyer lifts should be sanitized after every resident use to prevent contamination.

During the review of the policy titled Mechanical

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Lifts dated 2/14, indicated mechanical lifts per manufacturer guidelines and Monarch Healthcare Management Policy and Procedure. To transfer a resident from bed to chair: #17 disinfect lift after use. To put the resident back to bed: #15 Disinfect lift after use.

Hand hygiene:

R3's annual Minimum Data Set (MDS) dated 2/18/25, identified R3 was cognitively intact with diagnoses that included, schizoaffective disorder (a mental health condition that combines aspects of schizophrenia and mood disorder), diabetes mellitus (impaired ability to produce or respond to insulin) and hypertension (high blood pressure). R3's MDS identified that R3 needed substantial/maximal assistance for toileting hygiene, upper body dressing, and personal hygiene. R3 was dependent on staff for lower body dressing.

R3's care plan revised on 1/30/25, identified R3 had an alteration in elimination and increased incontinence due to urgency. R3 required assistance with toileting, and staff assisted with perineal cares in the morning, bedtime, and as needed. Staff needed to check incontinent products and assist in changing incontinent products as needed.

During an observation on 3/4/25 at 10:42 a.m., NA-A retrieved the mechanical lift from the hallway brought it into R3's room. NA-A applied a lift sling around R3. NA-C lifted R3 from the recliner transferred R3 into the bathroom and lowered R3 onto the toilet. When R3 said she was finished on the toilet, NA-C lifted R3 from the toilet. NA-A took a wet wipe and provided perineal

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F 880	Continued From page 41 care. NA-A discarded the wet wipe into the garbage and pulled up R3's brief and pants. NA-A then removed their gloves pushed R3 back to her recliner and lowered her into her recliner. NA-A During an interview on 3/4/25 at 11:07 a.m., NA-A confirmed she did not remove the gloves after doing perineal cares. NA-A indicated she was not trained to take off gloves after performing perineal cares and did not want to touch a resident without gloves. R9 R9's quarterly Minimum Data Set (MDS) dated 12/20/24, identified R9 as being cognitively intact with diagnoses that included, paraplegia (a type of paralysis that affects the lower half of the body) hypertension (high blood pressure), anxiety, and depression. R9's MDS identified that R9 needed substantial/maximal assistance for personal hygiene and lower body dressing. R9 care plan revised on 2/25/25, identified R9 had alternation in elimination weakness and paraplegia. R9 required assistance with perineal cares in the morning, bedtime, and as needed. R9 required assistance with incontinent products and to change incontinent products as needed. During an observation on 3/5/25 at 8:40 a.m., NA-D went into R9's room and asked R9 if she wanted to get dressed. NA-D got a basin of warm water and wipes. NA-D applied gloves. NA-D warmed the wipes in the warm water and applied soap. NA-D provided perineal care and discarded the wipe in the garbage. NA-D took a second wipe and rinsed off the soap. NA-D rolled R9 to the side right removed the soiled brief and	F 880		

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F 880	Continued From page 42 discarded the soiled brief in the garbage. NA-D then provided perineal care to her coccyx and buttock area with a wet wipe with soap, then rinsed off the soap with a clean wipe and discarded the wipe into the garbage. NA-D did not remove gloves and grabbed the clean brief and tucked the brief under R9 then had R9 roll to her left side and adjusted the brief. NA-D assisted R9 roll to her back, then applied a protective ointment to the perineal area. NA-D then rolled R9 to the right side, and NA-D applied the protective ointment to her buttocks and coccyx area. NA-D assisted R9 to roll to her back and NA-D fastened R9 brief. NA-D took the bed controller and put the bed down slightly. NA-D dumped the basin of water then dried the basin and placed the basin in the closet. While in the closet NA-D grabbed two pairs of pants and had R9 pick which pants she wanted to wear. Then went back to the closet and proceeded to touch and separate the clothing looking for a matching top. NA-D took the outfit to the bed and assisted R9 with putting on her pants. NA-D took the bed controller and lifted the head of the bed. NA-D noted there was not a sling for the mechanical lift, and NA-D said she needed to retrieve a sling. NA-D removed gloves and exited the room. During an interview on 3/5/25 at 11:06 a.m., NA-D confirmed she did not change gloves after removing the solid brief and continued to touch clean objects in the room such as clothes and the bed controller. NA-D indicated the normal practice was to change gloves after removing a soiled brief. During an interview on 3/5/25 at 11:07 a.m., CC stated she expected when doing perineal care, staff wipe from front to back and use different	F 880		

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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) COMPLETION DATE
F 880	Continued From page 43 wipes on different sides. CC expected staff to remove gloves after perineal care. During an interview on 3/5/25 at 12:14 p.m., DON indicated it is her expectation once staff is done with the dirty cares, gloves should be removed before continuing cares. Review of the policy titled Handwashing Policy dated 2/2024, stated proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: after changing incontinent products or cleaning up after someone who has used the toilet. Hand washing and gloves- When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		3/28/25

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	245361	A. BUILDING ______ B. WING ______	C 03/06/2025

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F 883	Continued From page 44 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R5)	F 883	Submission of this Response and Plan of Correction is not a legal admission that a	

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F 883

Continued From page 45

reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s).

Findings include:

A CDC Pneumococcal Vaccine Timing for Adults feature, dated 11/21/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer, after 5 years, the Pneumococcal 20-valent Conjugate Vaccine (PCV20) or Pneumococcal 21-valent Conjugate Vaccine (PCV21) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. This also identified an adult over 50 years old, who received one dose of PPSV23 at any age should be offered either option A (PCV20 or PCV21) or option B (PCV15) after one year.

R5's face sheet dated 3/5/25, indicated she admitted to the facility 10/22/24 and was 74 years old. The immunization record dated 3/6/25, indicated she received a PPSV23 on 12/31/19 and a PCV13 on 11/3/17. The record lacked evidence of shared clinical decision making with her physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R5 was offered or received PCV20.

When interviewed on 3/5/25 at 11:35 a.m., the director of nursing (DON) stated she was

F 883

deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F883 s/s D – Influenza and Pneumococcal Immunization

The process for satisfying this requirement has been reviewed and revised as necessary to ensure residents are offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC).

All residents residing in the facility have the potential to be affected if this

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F 883	Continued From page 46 responsible for the facility infection control program including ensuring resident eligibility for and offering routine vaccinations. The DON stated the facility procedure and expectation was to determine each resident's vaccine history and eligibility for vaccines upon admission. The DON acknowledged R5 had been eligible for the PCV20 however had not been educated on the risk and benefit or offered the PCV20 vaccine per CDC guidelines. The facility Pneumococcal Policy dated February 2024. Identified prior to admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. The facility policy also identified within 30 days of admission, the resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated and to refer to the current CDC recommended adult immunization schedule.	F 883	requirement is not met. R5 was offered the pneumococcal vaccine and gave consent. R5 has discharged from the facility. All residents were reviewed and audited to ensure compliance. Communication was completed with pharmacy services to obtain the necessary vaccine. All MMHR staff have received education utilizing the Monarch Healthcare Management Pneumococcal policy. Monitoring to assure compliance with this requirement will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; weekly for two (2) weeks, monthly thereafter for one (1) month. Any deficient practice will be corrected at the time of occurrence, and results will be reviewed at QAPI. The Director of Nursing or designee is responsible for compliance. Corrective action will be completed on or before 3/28/25.	

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	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/04/2025**

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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 03/04/2025. At the time of this survey, Meeker Manor Rehabilition Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2025

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K 000	Continued From page 1 Health Care 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. Meeker Manor is a one-story building with a partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction. 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	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 65 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.7.4, and 7.1.6.2. These deficient findings could have an pattered impact on the residents within the facility. Findings include: On 03/04/2025 between 9:15 AM to 11:45 AM, it was revealed by observation that the exit discharge sidewalk from lane 2 and lane 3 was not level. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 271	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to	4/20/25

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K 271	Continued From page 3	K 271	the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility’s credible allegation of compliance. K271 s/s E -During the walk-through it was observed that the sidewalk exits outside of doors 2 and 3 were not level. -In the event of an emergency, occupants attempting to exit through doors 2 and 3 have the potential to be affected if this regulation is not met. -Maintenance Supervisor has been re-educated to the requirement utilizing this regulation. -Maintenace Supervisor is currently obtaining bids to level the sidewalk and is scheduling appointments with contractors. -Corrective action is pending weather and availability of local contractors to bid and complete the work. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI.	

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K 271	Continued From page 4	K 271	-Maintenance Director or Designee is responsible party -Compliance goal date of 4/20/25	
K 353 SS=D	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 REQUIREMENT is not met as evidenced by: Based on observation 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, section 5.2.2.2. This deficient finding could have a isolated impact on the residents within the facility.	K 353	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	3/4/25

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K 353	Continued From page 5 Findings include: On 03/04/2025 between 9:15 AM and 11:45 AM, it was revealed by observation that there was a freon line zip tied to the sprinkler pipe located in the mechanical room by the Administrators office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K353 s/s D -During the walk-through it was observed that there was a freon line zip tied to the sprinkler pipe located in the mechanical room. -In the event of an emergency, occupants of this compartment may have the potential to be affected if this regulation is not met. -Maintenance Supervisor has been re-educated to the requirement utilizing this regulation. -Maintenance Supervisor removed the line and corrected the issue. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two	

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K 353	Continued From page 6	K 353	(2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action was completed on 3/4/25.	