Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 2, 2025

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

RE: CCN: 245361
Cycle Start Date: May 8, 2025

Dear Administrator:

On June 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2025

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

Re: Reinspection Results
Event ID: C20512

Dear Administrator:

On June 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 8, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2025

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

RE: CCN: 245361
Cycle Start Date: May 8, 2025

Dear Administrator:

On May 8, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 8, 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 November 8, 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.

Feel free to contact me if you have questions.

Sincerely,

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

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 05/08/2025

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
F 000	INITIAL COMMENTS On 5/05/25 through 5/08/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H53613270C (MN2411), H53614067C (MN112784), and H53614113C (MN112850) with deficiency cited at F684. In addition, the following incidental findings were found at F580, F609, F610, and F698. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		6/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/28/2025

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 580	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580

Continued From page 2

Based on interview and document review, the facility failed to provide timely notification to a provider for a change in condition related to low blood pressures for 1 of 1 resident (R2) who received dialysis and was already hypotensive.

Findings include:

R2's admission Minimum Data Set (MDS) dated 4/01/25, indicated R2 had renal insufficiency, diabetes mellitus, and depression. The MDS further indicated R2 received dialysis.

R2's Care Plan dated 4/08/25, indicated R2 was at risk for complications related to dialysis and alteration in oxygen/gas exchange, respiratory status directed staff to keep medical doctor informed of changes.

R2's physicians orders dated 3/28/25, indicated to take vital signs after dialysis one time a day every Monday, Wednesday and Friday.

Review of R2's blood pressures indicated the following from 4/01/25 to 5/01/25:

5/01/25- 96/56
4/30/25- 76/43
4/29/25- 93/56
4/22/25 -107/67
4/18/25- 111/69
4/17/25- 109/67
4/16/25-112/69
4/15/25-101/60
4/13/25- 111/67
4/11/25-107/96
4/10/25-92/56
4/09/25-92/52
4/08/25-92/58

F 580 (Plan of Correction)

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.

F580 s/s D
-The process for satisfying this requirement has been reviewed and revised as needed, to ensure necessary and appropriate notifications are made timely for residents with a change of condition.
-All residents have the potential to be affected if this regulation is not met.
-Appropriate notifications were made for R2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 3 4/02/25-97/58 4/01/25-100/62 During interview on 5/05/25 at 2:24 p.m., nurse manager (NM) stated she was unaware of the low blood pressure on 4/30/25, of 76/43 and was not sure if R2's physician or nurse practitioner (NP) was notified. NM stated the NP comes out weekly and checks the residents vital signs, so she should know, but probably could have been notified. During interview on 5/07/25 at 9:13 a.m., R2's NP stated she last saw R2 on 4/16/25, and her physcian saw her on 4/24/25. NP stated R2 was hypotensive due to her previous hospitalizations and from looking at the facility's portal, neither the NP or physician had been informed of R2's low reading on 4/30/25 of 76/43. NP added, that was concerning because a reading of 76 was very low for R2 and she would have had the staff retake the blood pressure and if it was still that low, she would probably have sent R2 into the emergency department (ED). The NP further stated it would only be standard nursing practice for the nurses to call and report a blood pressure that low even if there were not specific parameters on her blood pressure medications. In addition, NP stated she was unaware R2 was sent from dialysis on 5/02/25, to the ED with a blood pressure reading at dialysis of 62/45 and was now in the intensive care unit. Facility policy Notification of Changes Policy dated 3/2024, indicated It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician	F 580	-R2 has been receiving blood pressure checks as ordered by the physician. -All other residents with a recent change of condition were reviewed to ensure appropriate notifications have been made. -All necessary staff received education regarding change of condition protocol to ensure necessary and appropriate notifications are made timely for residents with a change of condition. -Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) 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 06/06/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 4 or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		6/6/25

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F 609 Continued From page 5

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to report to the state agency (SA) for 3 of 3 residents (R3, R5 and R6) reviewed when R3, R5, R6 were named in an external complaint of alleged abuse by facility staff and no report was made within two hours.

Findings include

R3 face sheet, undated, indicated R3 diagnoses of unspecified dementia with anxiety, hypertension, diabetes, chronic obstructive pulmonary disease.

R5 face sheet, undated, indicated R4 diagnoses of unspecified dementia, cognitive communication deficit, post-traumatic stress disorder, anxiety, Parkinson's disease.

R6 face sheet, undated, indicated R5 diagnoses of hemiplegia and hemiparesis, epilepsy, adjustment disorder with disturbance of conduct, major depressive disorder, anxiety, traumatic subarachnoid hemorrhage with loss of consciousness.

Facility was sent an anonymous email dated 4/28/25 at 9:04 a.m., which indicated "...residents are getting neglected and abused daily, wounds are not getting completed. TMAs (trained medication aides) are doing insulin sticks, charting nursing assignments. TMAs are also changing residents catherer [sic] and placing a new catherer [sic] not just the bag on NOC (nocturnal) shift. No showers are getting completed. [Facility administrator] does not care about the residents is all about cash flow for the

F 609

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.

F609 s/s D

-The process for satisfying this requirement has been reviewed and revised as needed, to ensure allegations of abuse are reported to the State agency no later than 2 hours.

- All residents residing in the facility have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 6 company. [Administrator]refused to listen to our concerns regarding cares and neglect and abuse. [TMA-A] was doing dressing changes in the morning shift to help nurses out in the morning. [TMA-A] has been giving insulin in the AM shift. [TMA-B] is TMA witness abusing the resident [R5]. [NA-C] we witnessed her slapping [R3]. [TMA-C] verbally abusing the residents. [Licensed Practical Nurse (LPN-B) is a nurse came to work high intoxicated. [Licensed Practical Nurse (LPN)-D] is LPN through ESHIFT Abusing the resident [R4]. We are reporting this to the state". Facility failed to report allegations of abuse to the SA within two hours of receiving alleged allegations. When interviewed on 5/8/25 at 2:13 p.m., administrator in training stated her role was to make the SA reports for the facility. Administrator stated the email was not reported to the SA due to "there was no valid information, and I believe it is an incorrect document." Administrator stated the email allegations were investigated within the 2-hour time frame with resident interviews and was able to conclude the allegations were unsubstantiated. Administrated stated she was not aware of the regulations indicating to report first and then start an investigation. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy revision date 4/2025, indicated if were suspicion of neglect, exploitation, or misappropriation of resident property must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury. If the suspected neglect, exploitation, or misappropriation of resident property did not result in serious bodily injury, the	F 609	the potential to be affected if this requirement is not met. - The plan of care for R3, R5, and R6 was reviewed and revised as needed to ensure there was no harm or lasting effects. - The incident was investigated, to include, but is not limited to, other like resident interviews completed to ensure there was no harm. - The investigation concluded that the allegation was unsubstantiated and there was no threat to residents. - All staff have received training utilizing Monarch Healthcare Management abuse prohibition policy, with an emphasis on reporting requirements according to the guidance by the Minnesota Department of Health (MDH), and to report suspected abuse within 2 hours regardless of if it’s substantiated or unsubstantiated. - Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) 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	

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F 609	Continued From page 7 reports must be made within 24 hours. Notify the Minnesota Department of Health (MDH) on the notification website immediately after discovery of the incident.	F 609	before 6/06/25.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate and protect residents for an allegation of abuse for 3 of 3 residents (R3, R5 and R6) when the facility received an external, anonymous email alleging allegations of abuse by facility staff. Findings include: R3 minimum data set (MDS) dated 2/28/25, indicated moderately impaired cognition and	F 610	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	6/6/25

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

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displayed verbal behavioral symptoms toward others.

R5 MDS dated 2/26/25, indicated moderately impaired cognition and no behavioral symptoms.

R6 MDS dated 4/2/25, indicated cognition intact and was social isolated at times.

Facility was sent an anonymous email dated 4/28/25 at 9:04 a.m., which indicated "...residents are getting neglected and abused daily, wounds are not getting completed. TMAs (trained medication aides) are doing insulin sticks, charting nursing assignments. TMAs are also changing residents catherer [sic] and placing a new catherer [sic] not just the bag on NOC (nocturnal) shift. No showers are getting completed. [Facility administrator] does not care about the residents is all about cash flow for the company. [Administrator]refused to listen to our concerns regarding cares and neglect and abuse. [TMA-A] was doing dressing changes in the morning shift to help nurses out in the morning. [TMA-A] has been giving insulin in the AM shift. [TMA-B] is TMA witness abusing the resident [R5]. [NA-C] we witnessed her slapping [R3]. [TMA-C] verbally abusing the residents. [Licensed Practical Nurse (LPN-B) is a nurse came to work high intoxicated. [Licensed Practical Nurse (LPN)-D] is LPN through ESHIFT Abusing the resident [R4]. We are reporting this to the state".

Facility investigation dated 4/28/25, identified an email from an unknown source. Facility completed an investigation which included a full house of resident interviews, staff interviews, wound audits, shower audits, insulin audits and catheter placement audits. All audits and

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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.

F610

-The process for satisfying this requirement has been reviewed and revised as needed, to ensure allegations of abuse are thoroughly investigated to protect residents from potential abuse.

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

- The plan of care for R3, R5, and R6 was reviewed and revised as needed to ensure there was no harm or lasting effects.

-An investigation was initiated and concluded that there was no abuse (to any residents) and the claims submitted anonymously were unsubstantiated.

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F 610	Continued From page 9 interviews were completed efficiently within the designated 2-hour timeframe, ensuring all tasks were performed in a timely manner and remained within the scope of practice. Report summary found allegations to be unsubstantiated. Additionally, investigation report revealed residents in question had confirmed that the reported events never occurred. All relevant audits were reviewed and verified, with no issues or discrepancies flagged during the process. Review of facility investigation failed to indicate interviews with all identified employees in the abuse complaint, failed to identify remove of employee during the investigation or protections put in place for residents and failed to identify a partial/non biased party completing the investigation. When interviewed on 5/9/25 at 2:13 p.m., administrator stated she had overseen the investigation but stayed out of the process as she was named in the abuse allegation. Administrator stated the social worker and other management completed interviews with the residents, but staff interviews were completed by herself. Administrator in training stated there was no suspensions of staff during the investigation and she was not interviewed. She additionally added, the data collect for the investigation was reviewed by herself and she concluded there was no abuse. The administrator identified she was not aware of facility policy indicated a separate party was to investigate when administration was an alleged perpetrator. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy, revision date 4/2025, indicated if the alleged perpetrator is a supervisor or department	F 610	- All staff have received training utilizing the Monarch Healthcare Management abuse prohibition policy, with an emphasis on interviewing and suspending named staff members according to the guidance by the Minnesota Department of Health (MDH). - Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) 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 by 6/06/2025.	

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F 610	Continued From page 10 head, the person will notify the alleged perpetrator's supervisor or the Vice President of Social Service & Behavioral Health. Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide needed care and services to 3 of 3 residents (R2, R4, R5) whose changes in health status were not adequately assessed and physician's orders and treatments were not administered. Findings include: Physician Orders and Lab Draws R2's admission Minimum Data Set (MDS) dated 4/01/25, indicated R2 had renal insufficiency, diabetes mellitus and depression. The MDS further indicated R2 received dialysis. R2's Care Plan dated 4/08/25, indicated R2 was	F 684	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	6/13/25

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at risk for complications related to dialysis and alteration in oxygen/gas exchange, respiratory status staff were instructed to keep medical doctor informed of changes.

R2's Hospital Discharge Orders dated 3/26/25, indicated diabetic diet, no need to follow a low salt diet, eating salt would be good (no fluid restriction was ordered).

R2's physicians orders dated 3/28/25, indicated to take vital signs after dialysis one time a day every Monday, Wednesday, and Friday.

A Provider Rounding Note at dialysis dated 3/31/25, from certified nurse practioner (CNP) indicated concern for on-going output from ostomy (a surgically created opening in the body, typically on the abdomen, to allow waste to exit the body), R2 received fluid replacement during dialysis and phosphorus supplements for low phosphorus. Facility called, order to supplement phosphorus from 500 milligrams (mg) twice daily to 1000 mg twice daily, in addition to give patient plenty of fluid high sodium high phosphorous foods.

Review of R2's Physician's orders dated 3/31/25, indicated regular diet, fluid restriction with high sodium diet. In addition, to give K-phosphorus oral tablet give 500 mg by mouth twice daily (1000 mg daily). R2's medical record lacked evidence the K-phosphors medication order was increased to 1000 mg twice daily or that R2 was removed from a fluid restricted diet to a fluid pushing diet.

A Dialysis Communications Record dated 4/25/25, indicated a blood pressure reading upon

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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 facilitys credible allegation of compliance.

F684 s/s D
- The process for satisfying this requirement has been reviewed and revised as needed, to ensure needed care and services are provided to those with changes in condition and as ordered by the physician.
-All residents residing in the facility have the potential to be affected if this requirement is not met.
- R2, R4, and R5 have been assessed and re-evaluated, with revisions made as needed to each of their care plans to ensure there was no harm or lasting effects, with no concern noted.
- Nursing staff have been re-educated on following physician orders to check blood pressures, provide medications, and complete lab draws utilizing Monarch Healthcare Management policy and procedure on the physician order process and treatment policy
-Nursing staff were educated on the dialysis process, to include the floor / charge nurse completing the dialysis communication form prior to going out and nursing staff need to be reviewing the form upon return; regardless of nursing

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F 684	Continued From page 12 arrival to dialysis of 83/49. two liters (L) of normal saline was given pretreatment along with 500 milliliters (ml) of normal saline. The Communication Record provided orders to start twice daily blood pressures. Review of R2's medical record failed to indicate twice daily blood pressures were started. Review of R2's blood pressures indicated the following blood pressures from 4/25/25 to 5/01/25: 5/01/25- 96/56 taken at 5:43 p.m. 4/30/25- 76/43 taken at 3:23 p.m. 4/29/25- 117/62 take at 1:46 p.m. standing (related to resident fall per policy) 4/29/25-116/68 taken at 1:47 p.m. lying (related to resident fall per policy) 4/29/25-110/72 taken at 1:48 p.m. sitting (related to resident fall per policy) 4/29/25- 93/56 taken at 12:07 a.m. During interview on 5/05/25, at 1:35 p.m., clinical manager (CM)-A for R2's outpatient dialysis unit stated for the last week R2 had arrived at their unit with low blood pressures. It had been communicated to the facility on the Communication Record on 4/25/25, to start checking R2's blood pressures twice daily. CM-A stated R2 has had extreme outputs from her ostomy, having to empty it up to twice every two hours which could lead to dehydration and low blood pressures. In addition, the CM stated they had called the facility but difficulty reaching a nurse and left a voice message with the nurse manager on 4/28/25, to give R2's orders for Hydrocortisone and Midodrine hydrocortisone (HCL) (medications to increase blood pressure). CM-A stated R2 would inform them she never	F 684	staff absences. Education completed utilizing Monarch Healthcare Management dialysis process/Dialysis communication form, and Hemodialysis policy. -Alike residents were reviewed and evaluated as required to ensure care and services are being provided in accordance with physician orders. - Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) 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 by 6/13/2025.	

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received her medications prior to dialysis and blood pressures were not checked prior to dialysis. CM-A stated it was her understanding R2 had only received her morning medications prior to dialysis on the morning of 5/2/25 but that the facility could also not get a blood pressure reading that morning and still sent her. Upon arrival to dialysis they had to take her reading manually and her blood pressure was 62/45, they attempted to give fluids of two liters but were unable to get her blood pressure up high enough to run dialysis and had to send her to the emergency department (ED).

During interview on 5/05/25 at 2:24 p.m., nurse manager (NM) stated she was out sick on 4/28/25 through 4/29/25, and when she returned to work on 4/30/25 she received the voice message and transcribed the order but R2 had already left for dialysis that day at 5:00 a.m. The NM stated R2 received her mediations as ordered on 5/2/25, prior to dialysis and was sent to the ED from dialysis due to being hypotensive.

R2's orders dated 4/24/25, from medical doctor (MD) indicated an order for basic metabolic panel (BMP) a common blood test that checks the levels of several important substances in your blood, providing information about your body's metabolism, kidney function, and fluid balance in the am (morning).

Review of R2's medical record lacked evidence the lab draw was completed by the facility.

During interview on 5/07/25 at 10:59 a.m., nurse manager (NM)-A stated their lab company comes out every Monday, Wednesday, and Friday when R2 is at dialysis so the nurses at the facility have

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to draw R2's blood. NM-A stated the health information (HI) staff who no longer worked at the facility did not acknowledge the order until 4/28/25, and she was out sick on 4/28/25 and 4/29/25. The NM-A stated she did attempt to draw R2's blood on 4/30/25 and 5/01/25 and was unsuccessful and on 5/2/25, R2 was sent to the hospital. NM-A stated she did not inform the physician, nor did she inform the director of nursing (DON). Review of R2's records lacked evidence of attempted blood draws.

During interview on 5/07/25 at 11:15 a.m., the facility's nurse practitioner (NP)-A stated the BMP lab was ordered to be taken on the morning of 4/25/25, and was never completed. In addition, there had been no communication the blood draw was unable to be be completed as ordered. On 5/02/25, the resident had to be sent to the hospital due to low blood pressure and what she was informed was low potassium and other electrolytes. NP-A stated if these labs were completed timely, it may have prevented her hospitalization.

Facility Hemodialysis Policy dated 11/22/19, indicated The Facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences. The Policy further indicated under Communication and Plan of Care information regarding the resident's dialysis treatment will be gathered from the discharging hospital, referral information, resident interview, and examination. Information will include but is not limited to, the location and frequency of their dialysis treatment, the type and location of their dialysis access site,

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medications, fluid, and diet restrictions. Ongoing communication and collaboration for the development and implementation of the dialysis plan of care should be maintained by the facility and the dialysis team.

Physician Orders and Lab Draws

R4's quarterly MDS dated 2/19/25, indicated R4 had anemia, HTN, diabetes mellitus, Hyponatremia and received daily insulin. In addition, R4's MDS indicated he was medically complex.

R4's nurse practitioner orders dated 4/23/25, indicated labs to be completed on Monday 4/28/25, for complete blood count (CBC), BMP, A1C (check for long lasting blood sugar levels), thyroid stimulating hormone (TSH), in addition to compression socks on in a.m., off in p.m.

During interview on 5/07/25 at 11:20 a.m., NP-A stated the orders were placed for R4 due to concerns of edema and congestive heart failure (CHF), and she wanted the labs completed prior to her next visit at the facility on 4/30/25. NP-A stated when she arrived for her visit on 4/30/25, she found the labs were not completed and there were no compression socks for R4. At that time R4 presented pale with edematous (full of fluid) and had to be sent to the ED.

R4's Physicians Orders indicated "Ok to send to ED for evaluation of SOB, weight gain, edema, history of hyponatremia."

Review of R4's medical record indicated no labs were completed on 4/30/25.

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R4's After Visit Summary dated 4/30/25, indicated R4 was seen for extremity swelling, and diagnosed with acute on chronic congestive heart failure. The Summary indicated R4 was given a diuretic Lasix at 1:15 p.m. at the emergency department (ED).

During interview on 5/07/25 at 1:48 p.m., clinical coordinator (CC) stated R4 already orders for compression stockings and refused to wear them, so she never re-ordered them. In addition, the CC stated the health information (HI) sets up the labs and was not sure why they were not completed for R4.

During observation and interview on 5/07/25 at 2:00 p.m., nursing assistant (NA)-B stated she worked full time with R4 and she was never informed to put compression stockings on him. NA-B stated if she were informed, she would at least attempt to put them on. NA-B then proceeded to enter R4's room to look for the compression stockings when R4 stated the ones he has were too tight but was willing to try a larger size. While NA-B opened his top dresser drawer there was two packages with each containing a single compression stocking, one was opened and the other was not.

During interview on 5/08/25 at 11:00 a.m., regional director of nursing services (RD) stated they need to measure R4 for new compression stockings.

During interview on 5/08/25 at 3:40 p.m., the director of nursing (DON) stated she found out today from their lab company on 4/28/25, the staff who was supposed to complete the lab draws called in, therefore no lab draws were completed

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at the facility. The DON further stated they have no system in place to know when labs are completed, and it is something they could look into.

Physician Orders

R5's admission MDS dated 5/01/25, indicated R5 was medically complex, had heart failure, seizure disorder and traumatic brain injury. The MDS further indicated R5 was cognitively intact, used a wheelchair, walker and needed supervision with activities of daily living.

R5's Hospital Discharge Orders dated 4/25/25, indicated order for lacosamide (anticonvulsant) 150 milligrams (mg) take one tablet by mouth two times daily in addition to Keppra (anticonvulsant) 1500 mg twice daily. The Hospital discharge orders additionally listed lacosamide as an allergy of R5's .

R5's Meeker Manor Rehabilitation Center Allergy Report dated 4/24/25, indicated R5 had allergy to lacosamide. Entered by facility health information (HI).

An Aeris portal Communication Note dated 5/07/25 (13 days after admission to facility), indicated a late entry written by the facility's director of nursing (DON), which stated, "Writer called Aeris for clarification on lacosamide medication due to allergy to medication. Resident had order on dc (discharge) summary from hospitalization on 4/25/25 of lacosamide 150 mg BID (twice daily). Resident had not received medication since admission, internal process being completed at this time. Resident has received scheduled Keppra 1500 mg BID, no

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seizure activity noted at this time. Triage provider stated to hold medication 5/07/25 and update neurology 5/08/25."

During interview on 5/07/25 at 11:40 a.m., NP stated she followed up with the NM on the floor asking why R5 was still not on lacosamide. The NP stated the NM informed her the neurologist had not returned her call yet. NP stated R5 had not had a seizure luckily but could not believe it had been since admission and there had been no follow through with R5's medication order due to an allergy. NP stated she spoke to R5's family member (FM)-A and it never was a true allergy and R5 had been taking the medication for at least the last month.

During interview on 5/08/25 at 2:00 p.m., R5's family member (FM)-B stated there was no true allergy to the medication and at one time R5 experienced bradycardia (low heart rate) but found that was not related to her medication lacosamide. FM-B stated R5 had been on the medication prior to being admitted to the facility.

Medication and Treatment Orders policy dated 2/2024, indicated orders for medications will be transcribed accurately and in a timely fashion, only authorized licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record.

Medication Error Procedure policy dated 1/2020, indicated the interdisciplinary team evaluates medication usage to prevent and detect adverse consequences and medication-related problems. Medication errors should be assessed, documented, and reported according to federal

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	245361	A. BUILDING ______ B. WING ______	C 05/08/2025

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
F 684	Continued From page 19 and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and facilities pharmacy policy for preventing and detecting adverse consequences and medication errors.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed ensure ongoing commuication and collaboration with dialysis services for 1 of 1 resident (R2) who had orders not implemented. Findings include: R2's admission Minimum Data Set (MDS) dated 4/01/25, indicated R2 had renal insufficiency, diabetes mellitus and had depression. The MDS further indicated R2 received dialysis. R2's Care Plan dated 4/08/25, indicated R2 was at risk for complications related to dialysis will attend dialysis and will have no uncontrolled bleeding from fistula, shunt, or central line. The care plan directed staff to ask resident how she feels about doing dialysis, communicate with dialysis social worker as needed, for uncontrolled bleeding call 911, treatment and dressing change per protocol to dialysis site per MD order, send communication sheet folder to dialysis with each	F 698	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	6/13/25

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F 698 Continued From page 20

run, fluid restriction per order. In addition, the Care Plan indicated and alteration in oxygen/gas exchange, respiratory status staff were instructed to keep medical doctor informed of changes. R2's Care Plan lacked to indicate R2 was hypotensive and to check blood pressures, in addition to resident was not to receive fluid restrictions.

Review of care plan dated 4/8/25 lacked detail on how the communication would be utilized between the facility and dialysis, what information was expected to be communicated (blood pressure reading) and who was responsible to ensure follow up on communication from dialysis. Additionally, care plan indicated a fluid restriction and then identified she was not to receive a fluid restriction.

R2's Hospital Discharge Orders dated 3/26/25, indicated diabetic diet, no need to follow a low salt diet, eating salt would be good (no fluid restriction was ordered).

R2's physicians orders dated 3/28/25, indicated to take vital signs after dialysis one time a day every Monday, Wednesday, and Friday.

A Provider Rounding Note at dialysis dated 3/31/25, from certified nurse practitioner (CNP) indicated concern for on-going output from ostomy (a surgically created opening in the body, typically on the abdomen, to allow waste to exit the body), R2 received fluid replacement during dialysis and phosphorus supplements for low phosphorus. Facility called, order to supplement phosphorus from 500 milligrams (mg) twice daily to 1000 mg twice daily, in addition to give patient plenty of fluid high sodium high phosphorous

F 698

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.

F698 s/s D
-The process for satisfying this requirement has been reviewed and revised as needed, to ensure there is ongoing communication and collaboration with the Dialysis center.
- All residents residing in the facility who received dialysis services have the potential to be affected if this requirement is not met.
- The plan of care for R2 was reviewed and revised as needed to ensure there was no harm or lasting effects.
- Other current like residents who receive dialysis services were reviewed as necessary with no concerns noted.
- The facility will follow the agreement with the Dialysis center to ensure communication and collaboration.
- Nursing staff obtained blood pressure parameters from medical provider for R2 and nursing staff were trained to timely obtain blood pressures as prescribed and to notify medical provider if outside of those parameters (low or high).
- To prevent recurrence, nursing staff have been re-educated on following physician orders to timely check blood pressures, provide medications, and complete lab draws. Education completed utilizing Monarch Healthcare Management policy and procedure on the physician order process and treatment policy

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F 698	Continued From page 21 foods. Review of R2's Physician's orders dated 3/31/25, indicated regular diet, fluid restriction with high sodium diet. In addition, to give K-phosphorus oral tablet give 500 mg by mouth twice daily (1000 mg daily). R2's medical record lacked evidence the K-phosphors medication order was increased to 1000 mg twice daily (2000 mg daily) or that R2 was removed from a fluid restricted diet to a fluid pushing diet. A Dialysis Communications Record dated 4/25/25, indicated a blood pressure reading upon arrival to dialysis of 83/49, and two liters (L) of normal saline was given pretreatment along with 500 milliliters (ml) of normal saline. The Communication Record provided written orders to start twice daily blood pressures. Review of R2's medical record failed to indicate twice daily blood pressures were taken after 4/25/25.. Review of R2's blood pressures indicated the following blood pressures from 4/25/25 to 5/01/25: 5/01/25- 96/56 taken at 5:43 p.m. 4/30/25- 76/43 taken at 3:23 p.m. 4/29/25- 117/62 take at 1:46 p.m. standing (related to resident fall per policy) 4/29/25-116/68 taken at 1:47 p.m. lying (related to resident fall per policy) 4/29/25-110/72 taken at 1:48 p.m. sitting (related to resident fall per policy) 4/29/25- 93/56 taken at 12:07 a.m. During interview on 5/05/25, at 1:35 p.m., clinical manager (CM)-A for R2's outpatient dialysis unit	F 698	-Staff have been re-educated to the requirement and need to review the dialysis communication form upon return from the dialysis center. T raining has been completed by utilizing the regulation and Monarch Healthcare Management dialysis process/Dialysis communication form, and Hemodialysis policy. - Audits will be 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 6/13/25.	

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F 698	Continued From page 22 stated for the last week R2 had arrived at their unit with low blood pressures. It had been communicated to the facility on the Communication Record on 4/25/25, to start checking R2's blood pressures twice daily. CM-A stated R2 has had extreme outputs from her ostomy, having to empty it up to twice every two hours which could lead to dehydration and low blood pressures. In addition, the CM-A stated they had called the facility but had difficulty reaching a nurse and left a voice message with the nurse manager on 4/28/25, to give R2's orders for Hydrocortisone and Midodrine hydrocortisone (HCL) (medications to increase blood pressure). CM-A stated R2 informed them she never received her medications and blood pressures were not checked prior to dialysis. CM-A stated it was her understanding R2 had only received her morning medications prior to dialysis on the morning of 5/2/25, but that the facility could also not get a blood pressure reading that morning and still sent her. Upon arrival to dialysis, they had to take her reading manually and her blood pressure was 62/45, they attempted to give fluids of two liters but were unable to get her blood pressure up high enough and sent her to the emergency department (ED). During interview on 5/05/25 at 2:24 p.m., nurse manager (NM) stated she was out sick on 4/28/25 through 4/29/25, and when she returned to work on 4/30/25 she received the voice message and transcribed the order but R2 had already left for dialysis that day at 5:00 a.m. The NM stated R2 received her mediations as ordered on 5/2/25, prior to dialysis and was sent to the ED from dialysis due to being hypotensive. NM did not know who or if anyone checked the voicemail when she was away from work.	F 698		

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F 698	Continued From page 23 Facilities Hemodialysis Policy dated 11/22/19, indicated The Facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences. The Policy further indicated under Communication and Plan of Care information regarding the resident's dialysis treatment will be gathered from the discharging hospital, referral information, resident interview, and examination. Information will include but is not limited to, the location and frequency of their dialysis treatment, the type and location of their dialysis access site, medications, fluid, and diet restrictions. Ongoing communication and collaboration for the development and implementation of the dialysis plan of care should be maintained by the facility and the dialysis team.	F 698		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: C20511

Dear Administrator:

The above facility was surveyed on May 5, 2025 through May 8, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: ______ B. WING ______	C 05/08/2025

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 5/05/25 through 5/08/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed H53613270C (MN2411), H53614067C (MN112784), and H53614113C (MN112850) with a licensing order issued at 0265. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		6/6/25

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2 265	Continued From page 3	2 265		

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide timely notification to a provider for a change in condition related to low blood pressures for 1 of 1 resident (R2) who received dialysis and was already hypotensive.

corrected

Findings include:

R2's admission Minimum Data Set (MDS) dated 4/01/25, indicated R2 had renal insufficiency, diabetes mellitus, and depression. The MDS further indicated R2 received dialysis.

R2's Care Plan dated 4/08/25, indicated R2 was at risk for complications related to dialysis and alteration in oxygen/gas exchange, respiratory status directed staff to keep medical doctor informed of changes.

R2's physicians orders dated 3/28/25, indicated to take vital signs after dialysis one time a day every Monday, Wednesday and Friday.

Review of R2's blood pressures indicated the following from 4/01/25 to 5/01/25:

5/01/25- 96/56
4/30/25- 76/43
4/29/25- 93/56
4/22/25 -107/67
4/18/25- 111/69

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2 265	Continued From page 4 4/17/25- 109/67 4/16/25-112/69 4/15/25-101/60 4/13/25- 111/67 4/11/25-107/96 4/10/25-92/56 4/09/25-92/52 4/08/25-92/58 4/02/25-97/58 4/01/25-100/62 During interview on 5/05/25 at 2:24 p.m., nurse manager (NM) stated she was unaware of the low blood pressure on 4/30/25, of 76/43 and was not sure if R2's physician or nurse practitioner (NP) was notified. NM stated the NP comes out weekly and checks the residents vital signs, so she should know, but probably could have been notified. During interview on 5/07/25 at 9:13 a.m., R2's NP stated she last saw R2 on 4/16/25, and her physcian saw her on 4/24/25. NP stated R2 was hypotensive due to her previous hospitalizations and from looking at the facility's portal, neither the NP or physician had been informed of R2's low reading on 4/30/25 of 76/43. NP added, that was concerning because a reading of 76 was very low for R2 and she would have had the staff retake the blood pressure and if it was still that low, she would probably have sent R2 into the emergency department (ED). The NP further stated it would only be standard nursing practice for the nurses to call and report a blood pressure that low even if there were not specific parameters on her blood pressure medications. In addition, NP stated she was unaware R2 was sent from dialysis on 5/02/25, to the ED with a blood pressure reading at dialysis of 62/45 and was now in the intensive care unit.	2 265		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5	2 265		

Facility policy Notification of Changes Policy dated 3/2024, indicated It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.

SUGGESTED METHOD OF CORRECTION:

The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.

TIME PERIOD FOR CORRECTION: twenty-one (21) days.