DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2025

Administrator
Meeker Manor Rehabilitation Center, LLC

600 SOUTH DAVIS AVENUE
LITCHFIELD, MN 55355

RE: CCN:245361
Cycle Start Date: November 3, 2025

Dear Administrator:

On November 3, 2025, a survey was completed at your facility by the Minnesota Departments 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

**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 February 3, 2026(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

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

**INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

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

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

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 CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Meeker Manor Rehabilitation Center, LLC** | **600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>On 11/3/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed: H53616743C (2655673). An incidental finding was discovered and cited at F880.<br><br>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.<br><br>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. | F0000 | | |
| F0880<br>SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F0880 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0880 SS = D | Continued from page 1<br>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 conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F0880 | | |

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| F0880 SS = D | Continued from page 2<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on document review, interview and observation, the facility failed to implement proper infection control when two nursing assistants were observed not following enhanced barrier precautions or hand hygiene during direct care for 3 of 5 (R2, R4, R5) residents reviewed for infection prevention.<br><br>Findings include:<br><br>Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents know to be infected with multi-drug resistant organisms as well as those at increased risk of multi-drug resistant organism acquisition (residents with wounds or indwelling medical devices)<br><br>R2's face sheet dated 11/3/25, indicated R2 was admitted 8/11/21 and had diagnoses of type II diabetes, mood disorder due to known physiological condition with depressive features and obesity.<br><br>R2's Quarterly Minimum Data Set (MDS) assessment dated 8/27/25 indicated she was severely cognitively impaired and had behavioral symptoms directed towards others. She was dependent on staff for all activities of daily living.<br><br>During an observation on 11/3/25 at 1:05 p.m., nursing assistants (NA)-A and NA-B prepared to assist R2 with cares and both NAs donned gloves. R2 was rolled to the side and NA-B provided perineal cares, removed the soiled brief and placed a new brief. NA-B did not change gloves or complete hand hygiene after removing soiled brief. NA-B applied cream to R2's perineal area and then removed her gloves. NA-B adjusted the bedding linens and emptied the trash can. NA-A and NA-B removed their gloves when they exited R2's room and then completed hand hygiene.<br><br>R4's face sheet dated 11/3/25, indicated R4 was admitted on 7/19/24 and had diagnoses of unspecified injury of cervical spinal cord, neuromuscular dysfunction of bladder, radiculopathy lumbosacral region (pinched nerve in spine), retention of urine and anxiety. | F0880 | | |

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| F0880 SS = D | Continued from page 3<br><br>R4's Quarterly MDS assessment dated 9/22/25, indicated R4 was cognitively intact and was dependent on staff for activities of daily living.<br><br>R4's care plan dated 11/3/25 indicated "resident is currently on enhanced barrier precautions related to catheter use. Staff to don/doff personal protection equipment (PPE) per enhanced barrier precautions while providing high contact cares."<br><br>R4's November Medication Administration Record (MAR) indicated R4 had the following orders:<br><br>-Suprapubic urinary catheter placed on 10/8/25. Catheter is recommended to be exchanged every 3-4 weeks and should be completed per facility/agency protocol. Start date 10/15/25.<br><br>-Change foley/suprapubic catheter bag on shower day. Start date 2/2/25.<br><br>-Monitor catheter output every shift. Start date 2/11/25.<br><br>-Staff to follow enhanced barrier precautions (EBP) every shift. Start date 7/19/24.<br><br>During an observation on 11/3/25 at 12:50 p.m., R4's door had a enhanced barrier sign posted on the door. The sign indicated which personal protective equipment (PPE) staff should don (put on) when providing high contact cares. Nursing assistants (NA)-A and NA-B were observed preparing to provide care to R4. NA-A put gloves on and brought the mechanical lift into R4's room. NA-B put gloves on and assisted in attaching the sling to the lift. Neither NA-A nor NA-B donned a gown as the posted sign directed. NA-A attached the catheter bag to the sling, R4 was transferred from her wheelchair to her bed. NA-A pulled down R4's pants and opened the brief, some fecal matter was present in the brief. NA-A provided perineal care with wipes and removed the dirty brief. NA-A changed gloves but did not complete hand hygiene. NA-A touched the mechanical lift and the catheter bag while transferring R4 to the toilet. NA-A started moving R4's personal items around the room while R4 was using the bathroom and opened up a clean brief. R4 continued to use the bathroom, NA-B moved the mechanical lift to the hallway. NA-A and NA-B doffed (removed) gloves and completed hand hygiene.<br><br>During an interview on 11/3/25 at 1:20 p.m., NA-A and NA-B donned gloves and went to assist R4 finish in the | F0880 | | |

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| F0880 SS = D | Continued from page 4<br>bathroom. NA-A and NA-B entered the room with no gown. R4 was transferred from the toilet to the bed, NA-B lowered the mechanical lift and unhooked the catheter bag. NA-A and NA-B removed the sling. NA-B provided perineal care. NA-B removed her gloves but did not complete hand hygiene. NA-B applied cream to R4's perineal area and placed a clean brief. R4 was dressed and transferred to recliner chair by both aides. NA-A changed gloves but did not complete hand hygiene before emptying the catheter bag. NA-A and NA-B removed gloves as they exited the room.<br><br>During an interview on 11/3/25 at 12:09 p.m., NA-A stated she should have worn a gown when emptying the catheter. She explained she was not paying attention to the signs on the doors. NA-A explained EBP entails a full gown, mask, gloves and face shield to help anyone from getting exposed to illnesses. Some residents just had Covid -19 infections which is why some other residents have EBP signs on the doors. R5 was not currently being catheterized, but there is a sign on the door to be overly cautious. Hand hygiene should be completed when leaving the room and after completing perineal care.<br><br>R5's face sheet dated 11/2/25, indicated R5 was admitted on 6/9/22 and had diagnoses of aftercare following joint replacement surgery, Crohn's disease, retention of urine, heart failure, mild cognitive impairment of unknown origin, and history of stroke.<br><br>R5's Quarterly MDS assessment dated 10/20/25, indicated R5 was cognitively intact and was moderately dependent on staff for activities of daily living.<br><br>R5's November and October MAR lacked an order for enhanced barrier precautions or straight catheterization.<br><br>R5's care plan dated 11/3/25 did not include interventions related to enhanced barrier precautions or catheterization.<br><br>During an observation on 11/3/25 at 1:15 p.m., R5's door had an EBP sign posted on the door. NA-A donned gloves and no gown before entering R5's room. NA-A wetted a washcloth and wiped R5's perineal area. NA-A dried the area with a dry washcloth and applied Nystatin powder. R5 pulled his pants up independently. NA-A did not change gloves or complete hand hygiene and began moving the bedside table and television remote.<br><br>During an interview on 11/3/25 at 2:04 p.m., NA-B stated EBP should be followed when emptying or changing | F0880 | | |

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| F0880 SS = D | Continued from page 5<br>catheters. She didn't wear a gown when providing cares to R4 because she wasn't emptying or changing the catheter. EBP means the resident has a contagious illness. Hand hygiene should be complete after every glove change and gloves should be changed before and after cares.<br><br>During an interview on 11/3/25 at 2:21 p.m., the licensed practical nurse (LPN)-A and care coordinator stated staff should wear a gown when they see an EBP sign on a resident's door. Staff should complete hand hygiene before and after the go into a room. After prompting, LPN-A expanded hand hygiene should also be done after providing perineal care. LPN-A stated it is her job to put up and remove EBP signs. When asked if R5 required EBP, she stated he has a rash but no open areas and did not have a catheter anymore so he would not require EBP. LPN-A went to go verify if R5 had an EBP sign on the door. She stated she would check with his wound nurse if she wanted to continue EBP and keep the sign posted.<br><br>During an interview on 11/3/25 at 3:20 p.m., registered nurse (RN)-A stated EBP should be followed when there is an outbreak or if a resident has a wound or a catheter. Staff should wash hands before and after completing patient cares. The nurse manager or the infection control nurse should oversee having the correct infection control signs on each resident's door. RN-A stated R5 did not have a catheter or a wound. He used to have a wound on his leg which is what the EBP was for, but another staff may have forgotten to remove the EBP sign.<br><br>During an interview on 11/3/25 at 3:35 p.m., the director of nursing (DON) stated there has been recent education on EBP and contact precautions. There have been a few infection prevention audits completed. There was some staff confusion about thinking EBP was only needed for catheter cares. EBP should be worn for anything hands on, including toileting, transfers and linen changes. Staff should be completing hand hygiene before entering rooms, leaving rooms and once their hands are soiled. Hands should be washed after changing gloves. The nurse manager oversees making sure infection control signs are correct, the DON also periodically checks to verify signage is correct.<br><br>The facility policy, Enhanced Barrier Precautions, last revised 4/2024 directs that staff should implement enhanced barrier precautions for residents with wounds, indwelling medical devices, and infections.<br><br>The facility policy, Handwashing Policy, last revised | F0880 | | |

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| F0880 SS = D | Continued from page 6<br>02/2024 directs that handwashing should be completed after changing incontinence products, after touching garbage, etc. when conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before and after using gloves. If hands are not visibly soiled, an alcohol-based hand sanitizer can be used. | F0880 | | |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2025

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

Re: Event ID: 1DA814H1

Dear Administrator:

The above facility survey was completed on November 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 11/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure.<br><br>The following complaint was reviewed: H53616743C (2655673). NO licensing orders were issued. | 20000 | | |



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

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| **Meeker Manor Rehabilitation Center, LLC** | **600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 20000 | Continued from page 1<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2025

Administrator
Meeker Manor Rehabilitation Center, LLC

600 SOUTH DAVIS AVENUE
LITCHFIELD, MN 55355

RE: CCN:245361
Cycle Start Date: November 3, 2025

Dear Administrator:

On November 3, 2025, a survey was completed at your facility by the Minnesota Departments 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

**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 February 3, 2026(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

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

**INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

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

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

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 CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Meeker Manor Rehabilitation Center, LLC** | **600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355** |

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| F0000 | INITIAL COMMENTS<br><br>On 11/3/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed: H53616743C (2655673). An incidental finding was discovered and cited at F880.<br><br>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.<br><br>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. | F0000 | | |
| F0880<br>SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F0880 | | |

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

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

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| F0880 SS = D | Continued from page 1<br>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 conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F0880 | | |

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| F0880 SS = D | Continued from page 2<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on document review, interview and observation, the facility failed to implement proper infection control when two nursing assistants were observed not following enhanced barrier precautions or hand hygiene during direct care for 3 of 5 (R2, R4, R5) residents reviewed for infection prevention.<br><br>Findings include:<br><br>Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents know to be infected with multi-drug resistant organisms as well as those at increased risk of multi-drug resistant organism acquisition (residents with wounds or indwelling medical devices)<br><br>R2's face sheet dated 11/3/25, indicated R2 was admitted 8/11/21 and had diagnoses of type II diabetes, mood disorder due to known physiological condition with depressive features and obesity.<br><br>R2's Quarterly Minimum Data Set (MDS) assessment dated 8/27/25 indicated she was severely cognitively impaired and had behavioral symptoms directed towards others. She was dependent on staff for all activities of daily living.<br><br>During an observation on 11/3/25 at 1:05 p.m., nursing assistants (NA)-A and NA-B prepared to assist R2 with cares and both NAs donned gloves. R2 was rolled to the side and NA-B provided perineal cares, removed the soiled brief and placed a new brief. NA-B did not change gloves or complete hand hygiene after removing soiled brief. NA-B applied cream to R2's perineal area and then removed her gloves. NA-B adjusted the bedding linens and emptied the trash can. NA-A and NA-B removed their gloves when they exited R2's room and then completed hand hygiene.<br><br>R4's face sheet dated 11/3/25, indicated R4 was admitted on 7/19/24 and had diagnoses of unspecified injury of cervical spinal cord, neuromuscular dysfunction of bladder, radiculopathy lumbosacral region (pinched nerve in spine), retention of urine and anxiety. | F0880 | | |

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| F0880 SS = D | Continued from page 3<br><br>R4's Quarterly MDS assessment dated 9/22/25, indicated R4 was cognitively intact and was dependent on staff for activities of daily living.<br><br>R4's care plan dated 11/3/25 indicated "resident is currently on enhanced barrier precautions related to catheter use. Staff to don/doff personal protection equipment (PPE) per enhanced barrier precautions while providing high contact cares."<br><br>R4's November Medication Administration Record (MAR) indicated R4 had the following orders:<br><br>-Suprapubic urinary catheter placed on 10/8/25. Catheter is recommended to be exchanged every 3-4 weeks and should be completed per facility/agency protocol. Start date 10/15/25.<br><br>-Change foley/suprapubic catheter bag on shower day. Start date 2/2/25.<br><br>-Monitor catheter output every shift. Start date 2/11/25.<br><br>-Staff to follow enhanced barrier precautions (EBP) every shift. Start date 7/19/24.<br><br>During an observation on 11/3/25 at 12:50 p.m., R4's door had a enhanced barrier sign posted on the door. The sign indicated which personal protective equipment (PPE) staff should don (put on) when providing high contact cares. Nursing assistants (NA)-A and NA-B were observed preparing to provide care to R4. NA-A put gloves on and brought the mechanical lift into R4's room. NA-B put gloves on and assisted in attaching the sling to the lift. Neither NA-A nor NA-B donned a gown as the posted sign directed. NA-A attached the catheter bag to the sling, R4 was transferred from her wheelchair to her bed. NA-A pulled down R4's pants and opened the brief, some fecal matter was present in the brief. NA-A provided perineal care with wipes and removed the dirty brief. NA-A changed gloves but did not complete hand hygiene. NA-A touched the mechanical lift and the catheter bag while transferring R4 to the toilet. NA-A started moving R4's personal items around the room while R4 was using the bathroom and opened up a clean brief. R4 continued to use the bathroom, NA-B moved the mechanical lift to the hallway. NA-A and NA-B doffed (removed) gloves and completed hand hygiene.<br><br>During an interview on 11/3/25 at 1:20 p.m., NA-A and NA-B donned gloves and went to assist R4 finish in the | F0880 | | |

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| F0880 SS = D | Continued from page 4<br>bathroom. NA-A and NA-B entered the room with no gown. R4 was transferred from the toilet to the bed, NA-B lowered the mechanical lift and unhooked the catheter bag. NA-A and NA-B removed the sling. NA-B provided perineal care. NA-B removed her gloves but did not complete hand hygiene. NA-B applied cream to R4's perineal area and placed a clean brief. R4 was dressed and transferred to recliner chair by both aides. NA-A changed gloves but did not complete hand hygiene before emptying the catheter bag. NA-A and NA-B removed gloves as they exited the room.<br><br>During an interview on 11/3/25 at 12:09 p.m., NA-A stated she should have worn a gown when emptying the catheter. She explained she was not paying attention to the signs on the doors. NA-A explained EBP entails a full gown, mask, gloves and face shield to help anyone from getting exposed to illnesses. Some residents just had Covid -19 infections which is why some other residents have EBP signs on the doors. R5 was not currently being catheterized, but there is a sign on the door to be overly cautious. Hand hygiene should be completed when leaving the room and after completing perineal care.<br><br>R5's face sheet dated 11/2/25, indicated R5 was admitted on 6/9/22 and had diagnoses of aftercare following joint replacement surgery, Crohn's disease, retention of urine, heart failure, mild cognitive impairment of unknown origin, and history of stroke.<br><br>R5's Quarterly MDS assessment dated 10/20/25, indicated R5 was cognitively intact and was moderately dependent on staff for activities of daily living.<br><br>R5's November and October MAR lacked an order for enhanced barrier precautions or straight catheterization.<br><br>R5's care plan dated 11/3/25 did not include interventions related to enhanced barrier precautions or catheterization.<br><br>During an observation on 11/3/25 at 1:15 p.m., R5's door had an EBP sign posted on the door. NA-A donned gloves and no gown before entering R5's room. NA-A wetted a washcloth and wiped R5's perineal area. NA-A dried the area with a dry washcloth and applied Nystatin powder. R5 pulled his pants up independently. NA-A did not change gloves or complete hand hygiene and began moving the bedside table and television remote.<br><br>During an interview on 11/3/25 at 2:04 p.m., NA-B stated EBP should be followed when emptying or changing | F0880 | | |

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| F0880 SS = D | Continued from page 5<br>catheters. She didn't wear a gown when providing cares to R4 because she wasn't emptying or changing the catheter. EBP means the resident has a contagious illness. Hand hygiene should be complete after every glove change and gloves should be changed before and after cares.<br><br>During an interview on 11/3/25 at 2:21 p.m., the licensed practical nurse (LPN)-A and care coordinator stated staff should wear a gown when they see an EBP sign on a resident's door. Staff should complete hand hygiene before and after the go into a room. After prompting, LPN-A expanded hand hygiene should also be done after providing perineal care. LPN-A stated it is her job to put up and remove EBP signs. When asked if R5 required EBP, she stated he has a rash but no open areas and did not have a catheter anymore so he would not require EBP. LPN-A went to go verify if R5 had an EBP sign on the door. She stated she would check with his wound nurse if she wanted to continue EBP and keep the sign posted.<br><br>During an interview on 11/3/25 at 3:20 p.m., registered nurse (RN)-A stated EBP should be followed when there is an outbreak or if a resident has a wound or a catheter. Staff should wash hands before and after completing patient cares. The nurse manager or the infection control nurse should oversee having the correct infection control signs on each resident's door. RN-A stated R5 did not have a catheter or a wound. He used to have a wound on his leg which is what the EBP was for, but another staff may have forgotten to remove the EBP sign.<br><br>During an interview on 11/3/25 at 3:35 p.m., the director of nursing (DON) stated there has been recent education on EBP and contact precautions. There have been a few infection prevention audits completed. There was some staff confusion about thinking EBP was only needed for catheter cares. EBP should be worn for anything hands on, including toileting, transfers and linen changes. Staff should be completing hand hygiene before entering rooms, leaving rooms and once their hands are soiled. Hands should be washed after changing gloves. The nurse manager oversees making sure infection control signs are correct, the DON also periodically checks to verify signage is correct.<br><br>The facility policy, Enhanced Barrier Precautions, last revised 4/2024 directs that staff should implement enhanced barrier precautions for residents with wounds, indwelling medical devices, and infections.<br><br>The facility policy, Handwashing Policy, last revised | F0880 | | |

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| F0880 SS = D | Continued from page 6<br>02/2024 directs that handwashing should be completed after changing incontinence products, after touching garbage, etc. when conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before and after using gloves. If hands are not visibly soiled, an alcohol-based hand sanitizer can be used. | F0880 | | |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2025

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

Re: Event ID: 1DA814H1

Dear Administrator:

The above facility survey was completed on November 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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 CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**11/03/2025** |
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|---|---|---|---|---|
| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 11/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure.<br><br>The following complaint was reviewed: H53616743C (2655673). NO licensing orders were issued. | 20000 | | |



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

Minnesota State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**11/03/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Meeker Manor Rehabilitation Center, LLC** | **600 SOUTH DAVIS AVENUE , LITCHFIELD, Minnesota, 55355** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 20000 | Continued from page 1<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |