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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 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 reports must be made within 24 hours. Notify the Minnesota Department of Health (MDH) on the notification website immediately after discovery of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], indicated moderately impaired cognition and displayed verbal behavioral symptoms toward others. R5 MDS dated [DATE], indicated moderately impaired cognition and no behavioral symptoms. R6 MDS dated [DATE], 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 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 head, the person will notify the alleged perpetrator's supervisor or the [NAME] 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 [DATE], 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [DATE], 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 [NAME] 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)

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	245361	A. Building B. Wing	05/08/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.