

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Meeker Manor Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to include the resident representative in development and implementation of the plan of care for one of one residents (R1) reviewed for residents rights.R1's quarterly minimum data set (MDS) dated [DATE], included R1 had moderate cognitive impairment and diagnoses of traumatic brain injury, stroke, and hemiplegia and hemiparesis (weakness or partial paralysis on one side of the body).R1's face sheet dated 8/28/25, included a contact for family member (FM)-A with the contact type of A/R Responsible Party and POA (power of attorney) Care.On 8/27/25 at 1:10 p.m., R1 was observed sitting in her power wheelchair with feet resting uncovered. Bilateral great toes (both big toes) were noted to have dark red, scab like appearance at base of toenail. No redness or drainage noted.R1's In-House Senior Services Consent form signed 4/16/21, included R1 would consent to podiatry in house.Provider order dated 7/30/25, included an order for a podiatry referral for foot care and bilateral toe sores.R1's progress notes included a late entry created on 8/28/25 and backdated for 7/31/25, included the podiatry order was discussed with R1 and she declined. Progress note failed to include update to resident representative and provider for refusal of service.R1's care conference summary dated 7/18/25, included an appointment should be set up for a nerve block injection.Email from health information manager (HIM) to care coordinator (CC)-A on 7/18/25, included an order was needed from R1's provider for the nerve block injection and requested assistance to obtain the order from the rounding provider.During interview on 8/28/25 at 10:16 a.m., CC-A stated she usually talked with the resident when a referral came in to see if they would like to pursue it. CC-A stated she spoke with R1 about the order for a podiatry referral but did not put a note in her chart at that time. CC-A stated R1's daughter was her decision maker and that she did not contact R1's daughter to inform her of the podiatry referral. CC-A confirmed R1's family requested an appointment for a nerve block inject be set up during the care conference. CC-A stated she informed HIM of the appointment request and was unsure what the status of the appointment was.During interview on 8/28/25 at 10:52 a.m., FM-A confirmed she was the decision maker and POA for R1. FM-A confirmed she had not been updated on the referral for podiatry to address R1's ingrown toenails. FM-A confirmed R1 has had nerve block injections in the past that the facility had coordinated. FM-A confirmed the family requested R1 have another appointment for a nerve block at the last care conference due to an increase in discomfort for R1. FM-A stated she had not had any updates on the nerve block appointment since the care conference.During interview on 8/28/25 at 11:47 a.m., HIM confirmed she set up appointments when a new order or referral came in and at the request of a family member or resident. HIM stated the facility had a podiatrist that came to the facility. Other residents choose to go to an outside clinic for podiatry needs. HIM stated she would not have been updated on a resident refusal after the appointment was set up so she was unsure if R1 refused podiatry. HIM confirmed CC-A informed her of the request for R1 to have an appointment set up for a nerve block. HIM stated she attempted to set up the appointment but was unable to due to needing a new order. HIM stated she sent an email to CC-A to request a new order be obtained for the nerve block injection. HIM confirmed she had not received the new order for the nerve block for R1.During interview on 8/28/25 at 12:30 p.m., regional nurse consultant (RNC) stated if a resident had a resident representative, they should have been updated and involved when a new order was obtained, or a consent was needed. RNC stated the provider should have been updated if the resident or family refused an order or referral. RNC stated a request for an appointment brought up during a care conference should have been addressed by the care team. The HIM and care coordinator should have worked together to get an order and set up the appointment. RNC confirmed an appointment request from 7/18 should have been addressed by 8/28. RNC stated it was important to have the resident and resident representative involved in planning of care for continuity of care and ensuring the resident's needs were met.Facility policy for care conferences requested and not provided.</p>		