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	11/21/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to clarify R5's oxygen (O2) order, reconcile the O2 order, and administer O2 as ordered for 1 of 1 (R5) resident reviewed for oxygen therapy. Findings include: Review of State Agency (SA) report, dated 9/21/25 at 7:17 p.m., identified R5's family member noticed an oxygen tank in R5's room that was not in use since their admission to the facility. R5's undated, current Minimum Data Set (MDS) list identified R5 was admitted [DATE] with diagnoses of obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). R5's 9/19/25, Orders Discharge Report identified R5 was to take oxygen (O2) 2 liters (L) by inhalation route at bedtime. R5's 9/19/25, Admission/Initial Data Collection assessment sheet identified in the respiratory status section related to oxygen needs was left blank. R5's 9/19/25, 48-Hour Care Plan identified R5 had an alteration in oxygen/gas exchange. The goal was to have adequate gas exchange with no cyanosis (bluish discoloration of lips, hands and nails occur due to lack of oxygen in the blood), shortness of breath, oxygen saturation greater than 90% on room air and a normal respiratory pattern. Interventions for nursing staff to monitor oxygen saturation as ordered and as needed, document on respiratory status, inform the medical provider of changes, and monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, or difficulty coughing up sputum. However, the care plan lacked indication and parameters for O2 therapy. R5's September Treatment Administration Record (TAR) identified R5 was to receive 2 liters of O2 at bedtime and was to start on 9/19/25. However, the order was transcribed as a nursing order vs. a physician's order, resulting in R5 not receiving oxygen therapy until 9/23/25. Observation and interview on 9/24/25 at 9:03 a.m., with R5 was in her room reported wearing a nasal cannula connected to an oxygen concentrator that was set at 2 liters (L). R5 reported O2 therapy was not administer until approximately 3 days later. On one occasion after her admission, an employee on the evening shift informed R5 that she did not need the O2 at night unless her oxygen saturation was under 90%. R5 noted she had no difficulty breathing at night. Staff removed her O2 this morning after and was only to receive 02 therapy at night. When asked how that made R5 feel, R5 voiced that R5 did not agree with the employee response and was not happy. R5's, September 2025 vitals sign sheet identified on:9/19/25, 122/63 blood pressure, pulse 77, 94% oxygen saturation on room air, and 18 respirations.9/20/25, 168/57 blood pressure, pulse 63, 96% oxygen saturation on room air, and 18 respirations.Overall, R5's medical record lacked vital sign assessment for 9/21, 9/22, and 9/23/25 before administration of O2 therapy. R5's 9/20/25 through 9/23/25, progress notes lacked evidence that R5 was to receive O2 therapy at night. Interview on 9/24/25 at 9:13 a.m., with licensed practical nurse (LPN)-A identified R5 was to have O2 at night, however, she had not entered R5's room this morning to assess R5 and was not aware R5 was still on O2 therapy this morning. Interview on 9/24/25 at 10:54 a.m., with director of nursing (DON), initially set up R5's oxygen tank and tubing and placed it in R5's room when R5 was admitted to the facility. Nursing staff was expected to review and implement R5's orders as directed and communicate updates during staff handover to certified nursing assistants (NA) of R5's treatment plan. Interview on 9/24/25 at 3:05 p.m., with LPN-B identified the health information manager inputs admission orders on point click care (PCC) (online electronic medical record software) and review and cosigns the (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. R5's O2 orders was placed as a nursing order incorrectly and acknowledged the O2 order was to be placed as a physician order. R5's physician was not called to clarify the O2 and provide a diagnosis for O2 use. After reviewing R5's medical record on PCC, she identified R5 had no vital sign assessments for 9/21, 9/22, and 9/23/25 and acknowledged that R5's O2 orders was not followed as prescribed. Interview on 9/24/25 at 5:00 p.m., with regional nurse consultant identified R5's care plan should have included indications and parameters of O2 use. Review of undated, current Oxygen Administration checklist identified nursing staff was to verify practitioner's order for use of oxygen therapy, gather necessary supplies and equipment, perform a baseline assessment that was to include vital signs, breath sounds, oxygen saturation level and physical assessment before administering oxygen therapy. Request of oxygen therapy policy was requested and not received during survey window.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and document review, the facility failed to ensure adequate supply of medication was obtained and administered as ordered for 1 of 3 sampled residents (R1) reviewed for pharmacy services.Findings include: Review of State Agency (SA) report on 9/15/25 at 8:30 a.m., identified the facility had not inform R1's family member that R1 did not receive her antibiotics and had missed 2 of 4 doses and nursing staff did not have access to retrieve emergency medications. R1's 8/25/25, Hospitalist Progress note identified R1 had a fall and obtained a hip fracture. On 9/2/25, while hospitalized R1 obtained a fever of 102 degrees (Fahrenheit). On 9/06/25, R1 had loose stools and was tested positive for clostridium difficile (C diff) (bacteria in the gut that causes severe diarrhea) on 9/06/25. R1's labs identified elevated white blood cell count (WBC) of 20.9. Vancomycin therapy was to start for R1's infection on 9/06/25 and had orders to continue administration of antibiotic therapy on R1's discharge summary. R1's September 2025, Medication Administration Record (MAR) identified R1 had a diagnosis of neoplasm (cancer) of the digestive organs, COPD, enterocolitis due to C -diff and right femur fracture. The MAR identified R1 had been prescribed vancomycin (antibiotic) 125 milligram (mg) four times a day for C-diff and was to take it in the morning, afternoon, evening and at night that started on 9/11/25 and ended 9/16/25. The MAR identified on 9/14/25 at 8:00am, 9/14/25 at noon, and 9/15/25 at 4:00 p.m., total of 3 doses of antibiotics was missed. R1's 911/25, 48 Hour Care Plan identified R1 was on enteric (minimize transmission of pathogens that cause gastrointestinal infections) precautions related diagnosis of clostridium difficile (C-diff). The goal was for nursing staff to follow enteric precautions, use appropriate communication to follow evidenced base practice and for staff to put on and take off personal protection equipment (PPE) per enteric precautions when providing high contact cares when entering R1's room. However, the baseline care plan lacked indication of antibiotic use for C-diff. R1's 9/12/25, Daily Skilled Note assessment sheet identified R1 had no active infections and was not on antibiotic therapy. R1's progress notes identified on: 1) 9/14/25 at 2:27 p.m., local pharmacy Polaris was informed that R1's vancomycin capsules was to be sent to the facility in liquid form. R1 agreed to receive vancomycin as an oral solution and the on-call provider was notified to send over R1's prescription for liquid vancomycin to be administered.2) 9/14/25 at 11:00 p.m., during nurse handover communication and narcotic count, R1's family member voiced concerns that R1 had missed scheduled doses of vancomycin. Nursing staff confirmed had missed scheduled doses earlier in the day. Both the physician and administrator was notified of the missed antibiotic dose. R1's family member was reassured and informed the local pharmacy was to be deliver the antibiotics to the facility later in the evening. Additionally, R1 was scheduled for a 5:00 p.m. dose, the medication was removed from the Cubex (machine that dispenses medications). A new order for vancomycin liquid was delivered to the facility at 10:00 p.m., on 9/14/25 and R1 received her second dose of the antibiotic that evening. Staff nurse called the family and left a voicemail that R1 had received her scheduled medications.Interview on 9/22/25 at 1:24 p.m., with interim director of nursing (DON) was to assign nursing staff access to the Ekit, which was called the Medbank (Cubex). The Medbank was located between the 200 and 300 unit. The process of enrollment was to include each nurse and/or trained medication aide (TMA) name to be registered in the system and was given a 4 digit pin number to access the system. Protocol of removing medications from the Medbank permitted TMA's access to remove general medications, except for narcotics. Nurses were permitted to remove emergency medications, including controlled narcotics but those required a pin number that was provided by the local pharmacy. Inside the medication room displayed a list of medications named the Medbank List that was to include what type of medication was stored in the Medbank and could be reviewed by the nurses and TMA's, when needed. Review of the undated, current Medbank List identified oral vancomycin 125 mg was noted to be in stock. Interview on 9/22/25 at 1:34p.m., with registered nurse (RN)-A identified she was assigned to work (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as a nursing aide on the floor on 9/14/25 during the morning shift on the 100 unit. A female agency staff nurse who worked on the100 unit had informed RN-A that R1 antibiotic was not available to administer to R1. RN-A called the pharmacy to informed them of the missing dose and requested the antibiotic to be sent to the facility. Pharmacy notified RN-A that the antibiotic was no longer available as a capsule but had a liquid form available for administration. R1 agreed to take the antibiotic as an oral solution and RN-A informed the agency nurse, administrator, and R1's physician of the missing antibiotics. She did not have access to the Medbank, was not aware that the vancomycin was stored in the Medbank, and did not reach out to other nurses in the building for assistance to remove the antibiotic from the Medbank. She was trying to work smarter, not harder and made the decision to call the pharmacy to send additional doses of the antibiotic to the facility, instead. Observation and interview on 9/22/25 at 2:15 p.m., with trained medication aide (TMA)-A and licensed practical nurse (LPN)-B identified medications could be removed from the Medbank (medication dispense machine), as known as the Ekit, under resident's name on the machine. LPN-B identified medications could be removed under the cycle count option displayed on the screen, type the name of the medication and a list was to appear that listed the quantity held, dosages available, and when the medication was last retrieve. Review of EKIT screen identified vancomycin had a quantity of 5 left in the machine and was last removed on 9/13/25 at 7:06 p.m. Interview on 9/22/25 at 2:33 p.m., with family member (FM)-A identified she had concerns with R1 not receiving her antibiotics. The facility had to call pharmacy on several occasions for additional doses to be sent to the facility. On, 9/14/25 FM-A approached a nurse on the 100 unit to verify if R1 had received the antibiotic. The agency nurse identified R1 had not received the antibiotic as ordered and appeared to not know how to retrieve the antibiotic from the Medbank. Interview on 9/22/25 at 3:01pm, TMA-B had worked at the facility over 5 years and was knowledgeable on how to operate the Medbank. The facility nursing staff and agency staff was provided access to the Ekit and could remove medications, when needed. She completed initial training on the Medbank when hired but was not aware of when the facility had provided additional training on the Ekit for the facility nurses. Interview on 9/23/25 at 1:09 p.m., with pharmacy technician identified R1's antibiotics was sent to the facility initially on 9/11/25 at 10:27 p.m., with a total supply of 7 capsules. The supply was to last no more than 2 days, and the antibiotic remaining doses was to be removed from the Medbank, by staff nurses at the facility. Once the Medbank was depleted of the antibiotic supply, nurses was expected to notify the pharmacy and place a request by phone, fax or email for additional doses to be delivered to the facility. Interview on 9/23/25 at 1:13 p.m., with licensed pharmacist identified R1 was to continue on her antibiotics for 8 days. She was not sure why R1 did not receive her antibiotics as scheduled and identified the facility had options to retrieve the medication from the Medbank if a dose was needed. If R1 had continued the antibiotic as prescribed, R1's infection would have improved. Interview on 9/23/25 at 4:05 p.m., with licensed practical nurse (LPN)-B identified she had worked at the facility under a year. The Medbank was available to nursing staff who administered medications on the units to residents. Nursing staff was directed to notify her when there was difficulty retrieving medications from the Medbank during her working hours. The facility also had an on-call nurse staff could reach out to on the weekends or overnight with troubleshooting problems with Medbank. She could not remember the last time the facility had conducted an in-service or training on the Medbank, but was aware both nurses and TMA's was given access to use the Medbank. Interview on 9/23/25 at 4:10 p.m., with LPN-C had been trained on the Medbank, years prior and was hired with a knowledge on how to operate the Medbank. She identified during her time working at the facility, several nursing staff have requested assistance from her to remove medications from the Medbank, when medications were not available on the medication cart or in the medication room. If there was a troubleshooting issues with the Medbank on the evening shift, she was directed to reach the on-call nurse, after hours for assistance. Interview on 9/23/25 at 4:25 p.m., with LPN-A identified the facility had implemented use of the Medbank approximately four years ago. In the past year, she was not aware if the facility had (continued on next page)

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