

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Living Meadows at Luther - Madelia		STREET ADDRESS, CITY, STATE, ZIP CODE 503 Benzel Avenue SW Madelia, MN 56062	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a person-centered care plan following significant changes in condition related to hydration status to reflect hospital discharge instructions for hydration management, fluid intake, and monitoring for 1 of 3 residents (R1) reviewed for hydration .R1's face sheet identified diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, nutritional deficiency, moderate protein-calorie malnutrition, and hemiplegia and hemiparesis affecting left non-dominant side.R1's Nutrition Assessment Worksheet dated 4/14/26 identified R1's estimated nutritional needs of 1,560 kcal/day (30 kcal/kg) and 52-62 grams of protein/day. The section labeled Fluid Needs contained an arrow pointing to the adjacent box; however, the box was blank and no daily fluid requirement was documented. The assessment identified R1's weight as 114.2 pounds and R1 required nectar-thick liquids.R1's care plan dated 1/17/25, identified potential for fluid volume deficit related to inadequate fluid intake, and dependent for fluid intake manifested by concentrated urine, confusion, constipation, and weight loss. Interventions included observe, document, and report to provider any signs/symptoms of dehydration including: decreased urine output, poor skin turgor, dry mucous membranes, confusion, hypotension, tachycardia, fever, sudden weight loss, headache, or dizziness; encourage, assist with fluid intake, and report changes in ability.R1's nutrition care plan dated 1/17/25, identified potential for hydration problems. Interventions updated on 5/20/26, included to offer extra fluids between meals for hydration in activities, in common areas, and in room. observe for signs/symptoms of dehydration.R1's ED note dated 5/6/26, identified R1 came to ED for critical lactate level drawn. R1 did not want IV antibiotics. Facility stated he had been eating and drinking well. R1 was drinking well in the ED and had already had 100 milliliters (mL) of water with no difficulty. Fluids need to be pushed a little bit more as he was somewhat dehydrated. Plan for discharge included but not limited ensure fluids are being offered every hour while awake. Monitor strict intake and output (I & O) for 48 hours.R1's ED note dated 5/7/26, identified R1 had returned to ED after he was reportedly to have refused water all night and has an intake of 450 mL output of 700 mL at facility. R1 had asked for water three times in the ED since arrival, which was less than an hour. admitted to hospital for IV hydration and antibiotic. R1's hospital discharge note dated 5/10/26, identified R1 had treatment for diagnoses that included dehydration. Comfort focused care with treatments to include every two-hour repositioning, offer water with every reposition, monitor I & O, may irrigate catheter with sterile normal saline as needed.In review of R1's record from 5/4/26 through 5/10/26, there was no indication R1's care plan was revised following two emergency department visits and a hospitalization to reflect hospital discharge instructions, including to encourage increased fluid intake, offer fluids every hour while awake, offer water with every two-hour (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245522 If continuation sheet Page 1 of 14

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repositioning, monitor strict intake and output, and monitor changes in output.R1's significant change MDS dated [DATE], identified R1 had moderate cognitive impairment. R1 had a mechanically altered diet. Dehydration/fluid maintenance were triggered during the assessment.R1's care area assessment (CAA) dated 5/29/26, identified dehydration/fluid maintenance were triggered based on clinical manifestations of dehydration which included altered lab values. R1 was at risk for dehydration due to poor intakes and need for nectar fluids, will develop care plan, continue current plan.Although R1's CAA identified the care plan would be developed, the care plan had not been updated following the clinical manifestation of dehydration.During an interview on 7/17/26 at 10:26 a.m., licensed practical nurse (LPN)-A and LPN-B were present. LPN-A and LPN-B reviewed R1's care plan. LPN-A stated there were no interventions in the care plan for fluid intakes after R1 returned from the hospital on 5/10/26. LPN-B could not find any interventions after hospitalization but stated there should be.During an interview on 7/17/26 at 11:15 a.m., director of nursing (DON) stated R1 had returned from the hospital on 5/10/26 and was on comfort cares. DON explained comfort cares involved residents still getting normal basic care needs that staff would provide to everyone. R1 should have had his care plan revised with interventions after hospitalization and when R1 returned to baseline.The facility care plan policy requested on 7/17/26, at 12:23 p.m. via email but not received		

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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 record review, the facility failed to monitor and assess a fluid intake to ensure a physician-ordered fluid restriction was implemented as prescribed for 1 of 1 residents (R2) reviewed for hydration. Findings include: R2's face sheet identified diagnoses of hypokalemia, hypo-osmolality and hyponatremia. R2's annual MDS dated [DATE], identified R2 had mild cognitive impairment. R2 had no difficulties with hearing, vision, or speech. R2 had a mechanically altered diet. R2 had impairment on one side of upper extremity and both sides of lower extremities. R2 used a walker and wheelchair for mobility. R2 was independent eating. R2's dehydration/fluid care plan dated 1/8/25, identified R2 had a potential for fluid volume deficit. Interventions included to observe/document/report signs/symptoms of dehydration including: decreased urine output, poor skin turgor, dry mucous membranes, confusion, hypotension, tachycardia, fever, sudden weight loss, headache, or dizziness. Updated on 3/16/26, Monitor fluid restriction per doctor order and report any concerns as needed. Encourage fluid intake, fluid restriction per order, and report changes in ability. R2's nutrition care plan dated 3/16/26, identified interventions updated on 7/6/26, to include 1,200 mL (milliliters) /24-hour fluid offer extra fluids between meals for hydration at activities, in common areas and in room. offer supplement in the form of 6 oz twice daily. R2's dehydration risk dated 7/5/26, identified a score of 10 indicating R2 was at risk for dehydration. R2's physician visit note dated 7/14/26, identified R2 was on a prescribed fluid restriction. Assessment/Plan included to continue monitoring hydration status, fluid restriction 1,200 mL/day. R2's paper Daily Fluid Intake Tracker records dated 5/1/26 through 7/6/26 identified a target fluid intake of 1,200 mL. Both the dietary and nursing Daily Fluid Intake Tracker forms included handwritten instructions of 240 mLs per meal, 180 mLs supplement twice daily, and 120 mLs total water pitcher (60 mLs twice daily). The nursing form also included the handwritten instruction, Do Not Chart Fluids Given by Dietary. The dietary form directed staff to Give to [name] Dietary Manager upon completion. Both forms included a preprinted fluid conversion reference (30 cubic centimeters [cc] = 1 ounce [oz], large glass = 8 oz, small glass = 4 oz, coffee cup = 6 oz). Neither form identified a calculated daily fluid total or documented the total amount of fluid R2 consumed each day from both nursing and dietary. There was no indication R1's fluid intake was evaluated or assessed to ensure the prescribed fluid goal of 1200 ml was met. Examples from the record included 5/1/26: The nursing Daily Fluid Intake Tracker documented fluids provided during medication passes, supplements, and snack/coffee. The daily total was left blank. The documented nursing intake totaled 780 mL. A separate dietary Daily Fluid Intake Tracker documented beverages including milk, orange juice, coffee, and water. The daily total was left blank. The documented dietary intake totaled 36 ounces (oz) (1,064 mL). The documented combined nursing and dietary intake totaled 1,844 mL, which exceeded R2's prescribed 1,200 mL daily fluid restriction by 644 mL. 6/13/26: The nursing Daily Fluid Intake Tracker documented fluids provided during medication passes, supplements, and free water provided at R2's request. The daily total was left blank. The documented nursing intake totaled 540 mL. A separate dietary Daily Fluid Intake Tracker documented beverages including orange juice, milk, coffee, and water. The daily total was left blank. The documented dietary intake totaled 1,320 mL. The documented combined nursing and dietary intake totaled 1,860 mL, which exceeded R2's prescribed 1,200 mL daily fluid restriction by 660 mL. 6/27/26: The nursing Daily Fluid Intake Tracker documented fluids provided during medication passes, supplements, and water. The daily total was left blank. The documented nursing intake totaled 390 mL. A separate dietary Daily Fluid Intake Tracker documented beverages including (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orange juice, milk, coffee, and water. The daily total was left blank. The documented dietary intake totaled 1,200 mL. The documented combined nursing and dietary intake totaled 1,590 mL, which exceeded R2's prescribed 1,200 mL daily fluid restriction by 390 mL. 7/6/26: The nursing Daily Fluid Intake Tracker documented fluids provided during medication passes, supplements, and water. The daily total was left blank. The documented nursing intake totaled 600 mL. A separate dietary Daily Fluid Intake Tracker documented beverages including orange juice, milk, coffee, and water. The daily total was left blank. The documented dietary intake totaled 1,200 mL. The documented combined nursing and dietary intake totaled 1,800 mL, which exceeded R2's prescribed 1,200 mL daily fluid restriction by 600 mL. Review of R2's laboratory results during June 2026 identified laboratory values relevant to monitoring R2's hydration status, including: R2's routine chemistry labs dated 6/3/26, identified blood urea nitrogen (BUN) 37 (normal 7-18), glomerular filtration rate non-African American (GFR non-AA) 55 (normal 60-9999), sodium 138 (normal 136-145), B-type natriuretic peptide (BNP) 2,329 (normal 5-450). BNP was considered a critical lab result. R2's routine chemistry labs dated 6/17/26, identified BUN 31, GFR non-AA 55, sodium 135, chloride 95 (normal 98-107). R2's routine chemistry lab dated 6/24/26, identified BUN 32, GFR non-AA 53, C02 33 (normal 21-32), chloride 95, sodium 135, GFR QST 34 (normal range for > or = 90 years not established). During an observation and interview on 7/16/26, at 3:49 p.m., R2 was not in her room. R2 had a 16 oz gray water pitcher in her room and a stack of 5 oz cups on her table. Licensed practical nurse (LPN)-A came to room and observed the lid of the water pitcher to have masking tape with 4 oz written on it. LPN-A opened the water pitcher and stated it seems like more than 120 mL in the water pitcher, which would be the daily allotment. LPN-A left R2's room and called the dietary department. LPN-A stated dietary told her they used a measuring cup to fill R2's water pitcher with 60 mL both day and evening and used the big gray pitcher. LPN-A stated she could not be certain whether R2 obtained additional water from the water fountain or refilled her water pitcher from the faucet in her room. During an observation and interview on 7/17/26 at 7:34 a.m., R2 was in her room watching tv with her feet up on a chair. R2 stated she liked water and it was ridiculous not being able to have it. R2 stated the facility never gave her much water at all I take what I get. R2 stated if she asked for extra water, staff would say they were going to get her some and would not return so she would wait until they replaced it. During an observation on 7/17/26 at 8:03 a.m., R2 had wheeled to her designated spot in the dining room and drank all her fluids before her meal was brought out to her. During an observation and interview on 7/17/26, at 9:00 a.m., dietary assistant (DA)-A was passing freshwater pitchers to residents. DA-A picked up the pitcher for R2 and opened it. There was ice in it and a small amount of water. DA-A stated yesterday's water pitcher could have been full because of the ice. During an interview on 7/16/26, at 10:00 a.m., nursing assistant (NA)-A stated R2 was on fluid restrictions and only could have a certain amount each day. NA-A did not mention what R2's fluid restriction was. During an interview on 7/16/26, at 10:19 a.m., NA-B stated R2 was on a fluid restriction, but she did not know why. NAs did not have anything to do with R2's fluids, the nurses and dietary would provide R2 with all fluids; NA's would ask nursing before giving fluids to R2. R2 had a form at the desk for filling out fluid intake but NA-B thought the nurses filled it out. R2 had small 5 ounce (oz) cups in her room that she used to rinse her mouth after brushing her teeth and dietary would provide a large water pitcher twice a day. R2 had a bathroom in her room with a sink so she could fill the water pitcher or 5 oz cups, if she wanted. NA-B was unsure if R2 took the 5 oz cups herself from the water fountain dispenser or if staff gave them to her but R2 was aware she was on fluid restriction. During an interview on 7/16/26, at 1:35 p.m., licensed practical nurse (LPN)-A stated dietary documented fluid intake unless a resident was on a fluid restriction. For residents on a fluid restriction, nursing (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed a daily fluid restriction form. R2 was on a 1,200 milliliter (mL)/24-hour fluid restriction for her sodium level. Nursing documented fluids provided with medication passes and supplements. LPN-A stated she attempted to use fluids provided with meals or from R2's water pitcher to administer noon and bedtime medications; however, if those fluids were unavailable, nursing would provide additional fluid and document the amount on the fluid restriction form. If R2 requested additional fluids, such as during activities, staff would provide a half cup and document the additional amount. LPN-A stated R2 usually drank her meal beverages immediately and frequently requested replacement drinks because she preferred them cold. LPN-A stated R2 appeared to be always thirsty and her family did not want staff to refuse fluids. LPN-A stated she had observed R2 obtain cups from the water fountain but had not personally observed R2 drinking from the water fountain or obtaining water from the bathroom faucet. LPN-A stated staff did not always have R2 in view and could not be certain whether R2 obtained additional fluids from those sources. Completed fluid restriction forms were given to the dietary manager (DM)-A each day; however, LPN-A was not aware of anyone reviewing the nursing and dietary records together to determine R2's total daily fluid intake or whether R2 met, exceeded, or remained below the prescribed 1,200 mL fluid restriction. LPN-A could not locate R2's registered dietitian assessment or the completed 24-hour nursing and dietary fluid intake records in the medical record. During an interview on 7/17/26 at 10:26 a.m., LPN-A and LPN-B were present at the nurse's station. LPN-B stated dietary decided what water pitcher would go in each resident's rooms. LPN-A stated there were some smaller blue mugs that dietary would pass at water pass but was not sure how it was decided which resident got which sized pitcher. LPN-A thought the large water pitchers were too big for a lot of the residents. LPN-A stated ice was considered a liquid and once melted would be considered 10 mL/2 ice cubes. LPN-B stated she would inquire with dietary about getting a smaller pitcher for R2. During an interview on 7/16/26, at 9:09 a.m., DA-A stated water pitchers were passed to residents twice a day. Dietary staff were aware of which residents were on thickened liquids and fluid restrictions. Water fountains were also available to residents to drink from when they were thirsty. During an interview on 7/16/26, at 12:54 p.m., DA-B stated they did not record the amount of fluid consumed from water pitchers except for R2, since she had a fluid restriction. The water pitchers were 16 oz. During an interview on 7/16/26, at 12:59 p.m., dietary manager (DM)-A stated R2 was on a fluid restriction due to her sodium level and was allowed 1,200 milliliters (mL) of water each day. Director of nursing (DON) and DM-A had divided up the total amount of fluids R2 could get from each department. R2 had fluids with breakfast, lunch, dinner, and water pass from dietary. Nursing had an amount they provided with medication pass which they recorded on a paper sheet and turned into DM-A each day. DM-A kept the daily totals in a soft file for R2. R2 did not ever seem to have a problem with hitting her goal intake amount. DM-A would not report R2's total fluid intake for the day to anyone or calculate the 24-hour total to identify overages or shortages. DM-A was unaware that R2 had 5 oz cups from the water fountain in her room and could not articulate if R2 drank from those during the day or from the water fountain to get extra fluid. During an interview on 7/17/26, at 11:15 a.m., DON stated dietary department decided what size water pitchers each resident had. DON was aware dietary had different sizes of water pitchers for residents. Dietary would get the totals for the fluid restriction and tally it up. It was all completed on paper. If DM-A had any concerns with fluid intake, she would bring them to the interdisciplinary (IDT) meeting. Currently no one at the facility would monitor fluid intake when DM-A was not working. The facility Encouraging and Restricting Fluids policy dated 10/2010, identified the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Document any evidence of dehydration such as (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight loss, confusion, drowsiness, dry skin etc.The facility's Resident Hydration and Prevention of Dehydration policy dated 10/2017 identified the facility would strive to provide adequate hydration and prevent dehydration. The policy directed:The dietitian will assess all residents for hydration as part of the comprehensive assessment, at least quarterly and more often as necessary.Minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments using current standards of practice.Physician orders restricting fluids will take priority over calculated fluid needs.Nurses will assess residents for signs and symptoms of dehydration during daily care.Fluid intake will be documented in the medical record.Dietary will report fluid intake of less than 1,200 milliliters (mL) per day to nursing.If inadequate fluid intake or signs and symptoms of dehydration are identified, intake and output monitoring will be initiated, the physician will be notified, and monitoring will be incorporated into the care plan.The dietitian, nursing staff, and physician will assess factors contributing to inadequate fluid intake.Laboratory tests may be ordered to assess hydration status when indicated.Nursing will monitor and document fluid intake, the dietitian will be kept informed of the resident's status, and the interdisciplinary team will update the care plan and document the resident's response to interventions until fluid intake and related factors are resolved.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess, monitor, and implement interventions to maintain adequate hydration for 1 of 3 residents (R1) reviewed for hydration. Findings include Findings include R1's face sheet identified diagnoses of nutritional deficiency, moderate protein-calorie malnutrition, and hemiplegia and hemiparesis affecting left non-dominant side. R1's care plan dated 10/18/24, identified potential for urinary tract infection (UTI) related to history of frequent UTI, indwelling urinary catheter. Interventions included to offer cranberry juice, identify and provide preferred fluids, and offer fluids. On 1/20/25, urinary incontinence with potential for altered urine pattern. Interventions dated 7/19/24, directed staff to encourage fluid intake, R1 had frequent UTI's and low/dark urine output, encourage fluids (if appropriate) as R1 preferred/allowed. R1's care plan dated 1/17/25, informed staff R1 also had a potential for fluid volume deficit related to inadequate fluid intake, and dependent for fluid intake manifested by concentrated urine, confusion, constipation, and weight loss. Interventions directed staff to observe, document, and report to provider any signs/symptoms of dehydration including: decreased urine output, poor skin turgor, dry mucous membranes, confusion, hypotension, tachycardia, fever, sudden weight loss, headache, or dizziness; encourage, assist with fluid intake, and report changes in ability. The nutritional care plan dated 1/17/25 identified R1 had a potential for hydration problems with interventions that directed staff to offer extra fluids between meals for hydration in activities, in common areas, and in room. observe for signs/symptoms of dehydration. R1's care plan dated 3/5/25, informed staff R1 had potential for alteration in bowel elimination related to decreased intake of fluid with the goal to be/remain free of discomfort or complications related to constipation. Interventions directed staff to keep fluids within reach, offer sips of fluid with cares. R1's care plan dated 4/29/25, informed staff R1 had a potential for altered renal function related to acute renal failure (2/20/25) manifested by urinary retention and decreased urinary output. Interventions included: assess, record, and report to physician as needed: changes in blood pressure, changes in mentation, new or worsening fatigue, new or worsening edema, nausea or vomiting, or muscle spasms or cramping; report any changes to nurse. R1's Nutrition Assessment Worksheet dated 4/14/26 identified R1's estimated nutritional needs of 1,560 kcal/day (30 kcal/kg) and 52-62 grams of protein/day. The section labeled Fluid Needs contained an arrow pointing to the adjacent box; however, the box was blank and no daily fluid requirement was documented. The assessment identified R1's weight as 114.2 pounds and R1 required nectar-thick liquids. During a phone interview on 7/17/26, at 10:06 a.m., registered dietician (RD)-A stated she completed R1's dietary assessment on 4/14/26. R1's fluid intake should be 1,560 mL which would be 30 per kilogram (kg). RD-A stated she would review progress notes, recent labs, DM-A's review on food and fluid intake from care conferences, and if the resident had intake and output (I&O) records while completing her assessments. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, difficulty communicating some words or finishing thoughts, sometimes missed part/intent of message but comprehended most conversation. No behaviors. Partial/moderate assistance with upper body dressing; partial/moderate assistance with eating and had a mechanically altered diet. In review of R1's record from 4/29/26 through 5/4/26, although R1's care plan identified a potential for fluid volume deficit related to inadequate fluid intake and directed staff to observe, document, and report signs and symptoms of dehydration, encourage and offer additional fluids, and report changes in ability, the record did not identify documentation of R1's daily fluid intake, nursing assessments evaluating whether R1 was receiving adequate hydration, (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or monitoring of signs and symptoms of dehydration. During this same period, nursing documented catheter urine output each shift; however, the record did not consistently document urine characteristics, such as color or concentration, or include any assessment identifying whether the amount of urine output was adequate in relation to R1's fluid intake. R1's catheter output on 4/29/26 was 100 milliliters (mL). R1's catheter output on 4/30/26 was 460 mL. R1's catheter output on 5/1/26 was 475 mL. R1's catheter output on 5/2/26 was 950 mL. R1's catheter output on 5/3/26 was 700 mL. R1's catheter output on 5/4/26 was 425 mL. R1's progress note dated 5/4/26 at 1:55 p.m., identified R1's foley catheter was removed and a new one was inserted. Procedure effective, dark urine. At 11:49 p.m., Acetaminophen 650 mg was given for pain/discomfort and fever. R1's progress note dated 5/5/26, at 2:46 a.m., identified R1 had bloody urine. At 3:02 a.m., R1 had been transferred to ED at 11:00 p.m. for evaluation due to a change of condition following a catheter change earlier in the morning with noted blood in urine. At approximately 9:15 p.m. R1 was warm to the touch. Vital signs: Temperature 101.6 F (normal 97.8-99.1), pulse 115 (normal 60-100), respirations 18/minute (normal 12-18), O2 saturations 95% on room air (normal 98-100), blood pressure 115/71 (normal 90/60-120/80). At 6:51 a.m., R1 was in ED all night. R1's emergency department (ED) note dated 5/4/26-5/5/26 identified R1 presented with blood in the catheter bag after a Foley catheter change. The facility reported R1 had a temperature of 100.0 F and was slightly tachycardic. Upon arrival to the ED, vital signs were within normal limits. A bladder scan showed very little urine in the bladder with no significant clots. Hematuria was present in the catheter bag with good catheter flow. Laboratory studies included CBC (complete blood count), CMP (complete metabolic panel), CRP (c-reactive protein) lactic acid, blood cultures, and urinalysis. Results included a creatinine of 1.4 mg/dL (normal 0.9-1.5 mg/dL), a white blood cell count of 26,000 with a left shift (normal 5,000-10,000 cells), a CRP of 12.2 (normal below 5), and a lactic acid level of 2.5 (normal 0.5-2.2 mmol/L). R1 received one liter of intravenous fluids and one gram of intravenous Rocephin. Following treatment, the lactic acid level decreased to 1.7. The ED discharged R1 back to the facility with oral antibiotics and instructions to repeat laboratory testing, monitor the urinary catheter for additional bleeding or changes in output, return to the ED if symptoms worsened, and encourage more water today. Diagnoses included UTI, sepsis, chronic indwelling Foley catheter, and acute kidney injury. R1's progress note dated 5/5/26, identified R1 returned from ED at 8:45 a.m. R1's catheter output on 5/5/26 was 500 mL. Although the ED included order to encourage more water and return if symptoms worsen, R1's record from 5/5/26-5/6/26, did not identify if R1 consumed more fluid and no indication if symptoms worsened. R1's laboratory results dated [DATE], identified lactic acid 2.9 (normal 0.4-2.0) this was a critical level. R1's progress note dated 5/6/26, at 10:35 a.m., identified facility nurse spoke with nurse at clinic regarding critical lab result of acid lactate 2.9. Updated on R1's condition of continued hematuria (blood in urine). Facility nurse spoke with MD-A who stated R1's overall condition was not improving. Send to ED for evaluation and/or observation. R1 transferred to ED at 12:20 p.m. following critical lab results. R1's ED note dated 5/6/26, identified R1 came to ED for critical lactate level drawn. R1 had a severe UTI and sepsis that could be life threatening. R1 did not want IV antibiotics. Facility stated he had been eating and drinking well. R1 was drinking well in the ED and had already had 100 milliliters (mL) of water with no difficulty. Fluids need to be pushed a little bit more as he was somewhat dehydrated. Plan for discharge was to stop Keflex (antibiotic) and start Levaquin (antibiotic); order at discharge included ensure fluids are being offered every hour while awake. Monitor strict intake and output (I & O) for 48 hours. R1's progress note dated 5/6/26, identified R1 returned from ED. Discharge orders included antibiotic for 10 days, monitor strict input and output for 48 hours. Follow-up appointment with provider on 5/8/26 at 10:15 a.m. R1's output upon return from (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Living Meadows at Luther - Madelia		STREET ADDRESS, CITY, STATE, ZIP CODE 503 Benzel Avenue SW Madelia, MN 56062	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ED was 400 mL.R1's Intake and Output record dated 5/6/26 following R1's ED visit on the evening shift documented 450 mL of fluid intake and 150 mL output on the evening shift since return from ED. The Intake and Output record did not identify overnight shift intake or output.R1's progress note dated 5/7/26, at 12:53 a.m., documented R1 complained of upper back pain. R1 was repositioned in bed and had an upper back massage. The note did not identify if fluids were offered or consumed. At 7:42 a.m., the note identified at 5:30 a.m., R1's brief was saturated in dark blood with bleeding around catheter tubing, in the catheter tubing, and bag. Output was 225 mL. R1 moaned and had facial grimaces, stated he had back pain. R1 was transported to ED.R1's catheter output on 5/7/26 during the night shift was 225 mL. There was no record of amount of fluid consumed on the shift.R1's progress note dated 5/7/26 at 1:53 p.m., identified R1 was admitted to the hospital with diagnoses at admission per MD were acute kidney injury, sepsis, and dehydration.R1's ED note dated 5/7/26, identified R1 had returned to ED after he was reportedly to have refused water all night and has an intake of 450 mL output of 700 mL at facility. Facility reported R1 complained of back, abdominal pain, and had blood in urine. R1 had asked for water three times in the ED since arrival, which was less than an hour. Assessment/Plan included Lactated Ringers 1,000 mL for sepsis, acute kidney injury and dehydration from low water intake overnight. admitted to hospital for IV hydration and antibiotic.R1's hospital discharge note dated 5/10/26, identified R1 had treatment for sepsis, UTI, acute kidney injury, dehydration, and pneumonia. comfort focused care with treatments to include every two-hour repositioning, offer water with every reposition, monitor I & O, may irrigate catheter with sterile normal saline as needed.R1's intake and output (I&O) record dated 5/10/26 identified a day shift intake of 230 mL with 625 mL output, and an evening shift intake of 180 mL with 350 mL output. No intake or output was recorded for the night shift. On 5/11/26, the record identified 595 mL intake with 600 mL output for the day shift. No intake or output was recorded for the evening shift. The night shift record identified 30 mL intake and 400 mL output.R1's MDS nurse note dated 5/11/26 at 1:15 p.m., identified R1 required intravenous fluids in the past seven days specifically to address the need for additional fluid intake and hydration needs. The need for fluids was determined by physical exam and/or diagnostic testing. Rehydration was reasonable and necessary.R1's physician order dated 5/12/26, identified to discontinue by mouth intake monitoring. comfort cares no need to monitor intake.In review of R1's record there was no other direction and/or monitoring developed to determine hydration status for maintaining comfort and/or prevent complications.R1's significant change MDS dated [DATE], identified dehydration/fluid maintenance were triggered during the assessment. R1 had moderate cognitive impairment. R1 had a mechanically altered diet.R1's handwritten Nutrition Assessment Worksheet dated 5/15/26 documented R1 received three times a day supplements prior to hospitalization. Intakes/Fluid section included Poor-overall decline during [illegible word] IVF during hosp-. The assessment did not include the amount R1 required to maintain adequate hydration.R1's care area assessment (CAA) dated 5/29/26, identified dehydration/fluid maintenance triggered based on clinical manifestations of dehydration which included altered lab values. R1 was at risk for dehydration due to poor intakes and need for nectar fluids, will develop care plan, continue current plan.Food and fluid intake records were requested for the period of 5/6/26 through 7/16/26; however, the facility only provided records from 6/1/26 through 6/8/26. Although the CAA identified R1's continued risk for dehydration and indicated the care plan would be developed, the record did not identify revisions to the care plan or documented interventions addressing the identified hydration risk. Review of the available dietary food and fluid intake records identified documented meal fluid intake and corresponding urine output; however, the documented amounts were not totaled, compared, or otherwise assessed to determine whether R1 was receiving adequate hydration.6/1/26: Breakfast (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 ounces (oz) (237 mL), lunch 8 oz, and dinner 4 oz (118 mL), for a documented total of 591 mL. Fluid output was 550 mL. 6/2/26: Breakfast 8 oz, lunch 8 oz, and dinner 4 oz, for a documented total of 591 mL. Fluid output was 325 mL. 6/3/26: Breakfast 4 oz, lunch 4 oz, and dinner 4 oz, for a documented total of 355 mL. Fluid output was 750 mL. R1's clinic note dated 6/9/26, identified R1 had completed course of antibiotic from hospitalization which had periods of lethargy, restlessness, and intermittent pain, along with poor oral intake and weight loss. Over subsequent weeks, symptoms stabilized and kidney function improved. Foley catheter remains in place with adequate output and no recent complications. R1's nursing assistant (NA) care sheet directed staff to offer sips of fluid with cares, encourage and assist with fluid intake and report changes. During an observation and interview on 7/16/26, at 9:09 a.m., dietary aide (DA)-A was passing water pitchers to resident rooms. DA-A stated water was passed twice a day; once on the morning shift and another time between 3:30 p.m.-7:00 p.m. DA-A stated dietary did not record fluid intake for water pitchers. During an interview on 7/16/26, at 11:52 a.m., NA-C stated R1 returned from the hospital really sick, which was why he was on comfort cares and had fluids offered every two hours. R1 did not like to drink but enjoyed thickened Coca-Cola and hot chocolate. Nursing assistants were supposed to offer small sips when they were in his room but did not have to report or document how much R1 drank. NA-C reviewed R1's Comfort Care Sheet that she explained needed to be completed every two hours. The top of the sheet had every two hours circled, and the day shift section listed handwritten times of 8:00 a.m., 10:00 a.m., 12:00 p.m., and 2:00 p.m., with no corresponding 1-4 entries documented. NA-C stated NA-B had not yet completed the sheet. NA-C stated all residents' care plans instructed staff to encourage fluids and that staff encouraged fluids while assisting residents with toileting. During an observation on 7/16/26, at 12:15 p.m., NA-C entered R1's room and asked if he wanted to get up for lunch, took him to the restroom, but NA-C did not offer R1 fluids while she was in R1's room. During an observation on 7/16/26 at 12:30 p.m., R1 was seated in a wheelchair at the dining room table with a glass of water in front of him, however, R1's wheelchair was positioned far enough from the table that he could not independently reach the glass. R1 took a sip of water from the mug that NA-C gave him. At 12:41 p.m., NA-C came back to the dining room and pushed R1 closer to the table and offered him a drink. At 12:46 p.m., licensed practical nurse (LPN)-B went to R1's table and handed R1 his mug. During an observation on 7/17/26, at 7:33 a.m., R1 was sitting in his recliner. R1's water pitcher was on the far side of the overbed table, and R1 attempted but was unable to reach it independently. At 7:42 a.m., unidentified NA offered R1 water, assisted him into his wheelchair, and transported him to the dining room for breakfast. At 7:46 a.m., R1 was seated at the dining room table without any beverages present. After R1 reached toward the table as if looking for a drink, staff provided water and hot chocolate. R1 immediately drank several sips of both beverages. At 7:52 a.m., R1 requested another glass of water. By 7:55 a.m., R1 had not yet received the requested water and continued signaling staff. Licensed practical nurse (LPN)-A subsequently provided another glass of water, which R1 immediately drank approximately half of, along with his nutritional supplement during medication pass. Staff later encouraged R1 to continue drinking, and by the end of the meal R1 had finished both glasses of water and consumed approximately one-quarter of his second cup of hot chocolate. During an interview on 7/16/26, at 10:00 a.m., NA-A stated she thought residents received new water pitchers every two hours. If a resident needed water, they would put on their call light then NAs would call for dietary to replace. NA-A explained dietary staff recorded how much fluid residents drank when they replaced the pitchers and would record meal intakes. Overnight NAs collected urine and documented the output at the end of their shift. On day shift overnight urine collection bags would be changed to leg bags; any urine output would be documented and included in the total output at the end (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the shift. NA-A indicated evening shift would be the opposite of day shift- staff removed the leg bag and applied the overnight bag recording any output for end of shift totals. During an interview on 7/16/26, at 10:19 a.m., NA-B stated R1 was able to drink on his own but occasionally needed encouragement. R1 was not always a good drinker, and staff were encouraged to offer fluids every two hours; otherwise, R1 would not drink. NA-B attempted to offer R1 fluids each time she entered his room. Sometimes R1 would take only a small sip, and NA-B would encourage him to drink more. NA-B stated R1 never refused fluids. R1 had more urine output after staff encouraged fluids following his return from the hospital. NA-B was unaware of the specific amount of fluid R1 was expected to receive each day. NA-B explained water pitchers were passed by dietary on the day and evening shifts. NA-B thought fluid intake was documented by either dietary staff or nurses but stated nursing assistants did not document fluid intake in the medical record. NA-B stated catheter output was documented in the morning and at the end of the shift. NA-B reviewed the paper rounding sheet used for R1 and stated it contained a numbered system (1-4) identifying care tasks, with 4 representing drinks. NA-B stated staff marked 4 when fluids were offered but could not explain how staff would determine or document the amount of fluid R1 consumed. During an interview on 7/17/26, at 9:03 a.m., NA-D stated R1 would be able to drink by himself from his water pitcher if it wasn't full. NA-D thought a smaller pitcher would help R1 be able to drink independently. During an interview on 7/16/26, at 1:35 p.m., LPN-A stated R1 did not always accept fluids when offered and preferred hot chocolate, Coca-Cola, and chocolate nutritional supplements. LPN-A stated R1's fluid intake declined after an order dated 12/16/25 changed R1 to nectar-thick liquids, and R1 required increased encouragement to drink thereafter. Before hospitalizations nursing assistants had reported R1's urine had been dark for a long time but did not exhibit signs of a urinary tract infection, so staff generally attributed dark urine to poor fluid intake and encouraged additional fluids. After staff encouraged fluids, R1's urine output increased and appeared less concentrated. LPN-A stated R1 frequently had a dry mouth and sunken eyes. LPN-A stated that in early May 2026 R1 began experiencing problems with his Foley catheter and required multiple emergency department evaluations before ultimately being admitted to the hospital with sepsis, dehydration, and acute kidney injury. Following his hospitalization, R1 returned to the facility on comfort care but was not enrolled in hospice. R1 was asking for water more frequently than usual after returning from the hospital, which was unusual for him. Although R1 eventually returned to his baseline, he continued to require frequent encouragement to drink fluids. LPN-A stated dietary normally documented residents' fluid intake unless a resident was on strict intake and output (I&O), in which case nursing documented intake and output. R1's fluid intake was not routinely monitored by nursing because he was not on I&O except when ordered. LPN-A was unable to locate R1's registered dietitian assessment in the electronic medical record and did not know whether dietary food and fluid intake records were scanned into the record. LPN-A stated each nursing shift documented urine output for that shift; however, no one calculated or monitored R1's total urine output over a 24-hour period. If the facility was strictly monitoring I&O, staff should total both intake and output, but LPN-A had never seen a form documenting 24-hour totals for R1. After reviewing R1's urine outputs from May 1 through May 7, 2026, LPN-A stated R1 normally produced approximately 250 to 300 mL of urine per shift, and outputs of 100 to 150 mL would prompt nursing to consider reasons for the decreased output, including catheter obstruction or inadequate fluid intake. LPN-A stated catheter flushing was performed as needed based on nursing judgment, and nursing assistants were expected to report changes such as bloody urine or decreased output to nursing staff. During an interview on 7/16/26, dietary aide (DA)-B had a three-ring binder and was going table to table recording residents' food and fluid intake. DA-B was documenting fluid intake and considered (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one mug to equal 8 ounces (oz). If a resident drank half the mug, he recorded 4 oz. If a resident consumed two 8 oz glasses during the meal, he documented the intake as 8.8. The record documented the amount of fluid consumed but did not identify the type of fluid. DA-B stated Dietary Manager (DM)-A collected the records after meals and kept them in a large folder in her office. DA-B further stated water pitchers were not included in the recorded fluid intake when they were picked up. During an interview on 7/16/26, at 12:59 p.m., DM-A had paper that she stated were resident food/fluid intake records. DM-A collected the record and then would place the records in a file cabinet. DM-A did not normally review the amounts of food/fluid residents had each meal but would review the food/fluid intake record a week or so before the resident care conference and complete a dietary assessment. R1 was considered at-risk so fluids were encouraged but not monitored. DM-A did not have the dietitian recommendation for how much fluid R1 should have in a day and was unaware how much he should have but stated she could email the registered dietitian (RD)-A and get a copy. Usually, R1 just got the standard amount of beverages for meals, so he would have three 8 oz glasses at meals. During a phone interview on 7/17/26, at 10:06 a.m., RD-A stated nursing and dietary were to encourage and offer as much fluid as they could when R1 returned from the hospital. RD-A stated she did not specify in the assessment how much fluid to offer because they were thinking about hospice. RD-A stated she completed dietary assessments quarterly and with MDS's. When RD-A noticed an issue with a resident's assessment, she would notify the team (nurse, anyone who might be involved in the resident's care). RD-A stated the facility did not have a good process in place and there was a lot of work that needed to be done with coordination of dietary assessments and nursing. RD-A could not articulate why the facility did not have access to the dietary assessments she completed. RD-A was not aware of how nursing monitored fluids on R1. During an interview on 7/17/26, at 8:30 a.m., LPN-B stated she did not have access to registered dietitian assessments. During a follow-up interview on 7/17/26, at 10:26 a.m., LPN-A and LPN-B were present. LPN-A and LPN-B stated they did not complete intakes on R1 so would not be able to verify if he received 1,560 mL of fluid each day. LPN-B stated the nurse would not look at intakes unless it was ordered. R1 had an order when he returned from the hospital, but that was discontinued on 5/12/26, because R1 was on comfort cares, so no need to monitor. Comfort care meant the staff were to keep the residents comfortable and included being pain free, repositioning, not having skin breakdown. Staff would still do cares and treatments on residents, including providing fluids and medications. Nurses would notify families if residents were not doing good so they could decide if they wanted hospitalization or to remain at facility. R1 slowly improved and returned to baseline a few weeks after being back at the facility. During an interview on 7/17/26, at 11:15 a.m., director of nursing (DON) stated she expected staff to offer fluids to R1 when he was awake. However, she would not expect staff to wake him up during the night unless there was an order that specifically said to wake R1 up and offer fluids. DON thought if it was a critical situation the ED would have hospitalized R1 to give IV fluids. DON stated R1 did have lower urinary outputs in the beginning of May as she reviewed them but recently they were 900-1,000 mL/day. Currently, no one monitored the 24-hour outputs, but DON stated it would make sense to monitor them. DM-A monitored fluid intakes, and if she noticed an issue, she would bring to interdisciplinary (IDT) meeting. Currently, the monitoring is all done on paper by the dietary department and not available on the computer. DON could not articulate how the fluid intake was monitored on the weekends or when DM-A was out of the office. R1 had the best fluid intake in the morning and by supper it was like a rock and a hard place, some days better than others. DON stated R1 should have had strict I & O started after he returned to his baseline to monitor dehydration. During a phone interview on 7/17/26, at 1:09 p.m., medical doctor (MD)-A stated dehydration could cause (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acute kidney injury and harm. Those two diagnoses indicate that fluids were not offered enough and R1 got dry. MD-A would expect the facility to monitor the 24-hour urine output, and if they did not, nurses should at least review the previous 2-3 shifts nurse's notes and put a nursing order in to increase fluids and notify the provider. MD-A hoped that an experienced nurse would look at a foley bag, notice the contents were dark, and pass on the information to monitor. The facility Encouraging and Restricting Fluids policy dated 10/2010, identified the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Document any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin etc. The facility Output Measuring policy dated 10/2010, identified the purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period. The facility Intake, Measuring, and Recording policy dated 10/2010, identified the purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. A Table identified Resident served 8 oz glass of water + 240 mL, leftover fluid 3 oz = 90 mL, total liquid consumed 5 oz = 150 mL. The facility Resident Hydration and Prevention of Dehydration policy dated 10/2017, identified the facility would strive to provide adequate hydration and to prevent and treat dehydration. The dietitian will assess all residents for hydration as part of the comprehensive assessment, at least quarterly, and more often as necessary per resident need. Minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments, using current standards of practice. Physician orders to limit fluids will take priority over calculated fluid needs. The dietitian may refer calculated needs to the physician if restrictions potentially increase risk for dehydration. The dietitian and nursing staff will educate the resident and family regarding hydration and preventing dehydration. Nurses will assess for signs and symptoms of dehydration during daily care. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical records. Dietary will report intake of less than 1200ml/day to nursing staff. If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. ADL status, diagnosis, individual preferences, habits, and cognitive and medical status will be considered in all interventions. The physician will be notified. Orders may be written for extra fluids to be encouraged between meals and/or with medication passes. A specific minimum amount should be included in the order (e.g. 240ml fluids BID with medication pass). Force fluids is not an appropriate order. Encourage fluids is not an adequate order. The dietitian, nursing staff, and the physician will assess factors that may be contributing to inadequate fluid intake. Orders for medications that may exacerbate dehydration (e.g., diuretics) will be reviewed and held if medically appropriate. Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significant dehydration. If laboratory results are consistent with actual dehydration, the physician may initiate IV hydration. Hospitalization will be recommended, as necessary. Nursing will monitor and document fluid intake and the dietitian will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and relating factors are resolved.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to complete hand hygiene for 1 of 1 resident (R1) who was observed for quality of care. Findings include: R1's face sheet identified diagnoses of hemiplegia and hemiparesis (mild to moderate weakness) affecting left non-dominant side. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had a urinary indwelling catheter, was frequently incontinent of bowels and required substantial/maximum assistance from staff for toileting hygiene. During an observation on 7/16/26 at 12:04 p.m., R1 was in his room sitting in his recliner. At 12:15 p.m., nursing assistant (NA)-C entered the room to prepare R1 for lunch. NA-C transferred R1 to his wheelchair, wheeled him into the bathroom, and donned gloves without first performing hand hygiene. NA-C lowered R1's pants and brief, removed the soiled brief, and placed it in the trash receptacle. Without removing her gloves or performing hand hygiene, NA-C handled and applied a clean brief to R1 while R1 remained seated on the toilet. R1 then stood, and NA-C wiped R1's buttocks. When the wipe was removed from R1's rectal area, brown-colored stool was observed on the wipe. NA-C discarded the wipe in the trash receptacle; however, without removing her contaminated gloves or performing hand hygiene, NA-C pulled up R1's clean brief and pants, tied R1's pants, touched the arm of the wheelchair, placed a gloved hand on R1's gait belt, released the wheelchair brakes, propelled R1 out of the bathroom, and removed the gait belt. NA-C then removed her gloves, removed the garbage bag from the trash receptacle, placed a new liner in the receptacle, took the garbage bag down the hall to a garbage bin, discarded it, and performed hand hygiene. A phone call was placed to NA-C on 7/17/26, at 1:55 p.m. with no return call. During an interview on 7/17/26, at 1:33 p.m., NA-E stated she would usually perform hand hygiene between glove changes. NA-E would put on gloves prior to taking a resident to the bathroom, remove her gloves after touching soiled products, perform hand hygiene, and then put on clean gloves. During an interview on 7/17/26, at 1:41 p.m., infection preventionist (IP)-A stated staff had recently completed education on perineal care and hand hygiene. IP-A stated staff were expected to remove soiled gloves, perform hand hygiene, and don clean gloves when providing resident care in accordance with the facility's infection control policies and procedures. The facility Handwashing/Hand Hygiene policy, revised 9/28/23, included, but was not limited to, the following directions for staff: Hand hygiene is the primary means to prevent the spread of infections. Personnel shall follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Perform hand hygiene before moving from a contaminated body site to a clean body site during resident care. Perform hand hygiene after contact with blood or body fluids. Perform hand hygiene after contact with objects in the immediate vicinity of the resident. Perform hand hygiene after removing gloves. The use of gloves does not replace handwashing/hand hygiene.		