STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Meadows at Luther - Madelia	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R13) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include: R13's facesheet received 3/26/25, included diagnoses of Alzheimer's disease with early onset, osteoarthritis and spasticity (a condition with increased muscle tone, stiffness and involuntary muscle contractions). R13's quarterly (MDS) assessment dated [DATE], indicated R13 had severely impaired cognition, and no behaviors. Activities of daily living (ADL's) included R13 uses a wheelchair and is dependent on staff for transfers, bed mobility, locomotion and for eating. R13 has no current skin issues but is at high risk for development of pressure ulcer. R13 has had no recent weight loss or gain and is incontinent of bowel and bladder. R13's Braden Scale for Predicting Pressure Sore Risk dated 12/24/24, had a score of 12 indicating R13 is at risk for skin breakdown. R13's care plan dated 4/10/24, indicated R13 has a potential for impaired skin integrity and is high risk for skin breakdown with interventions including: apply ointments/medications as ordered, use pressure reducing devices (mattress on her bed and cushion in her chair), assist with hygiene and general skin care. Avoid using hot water for cleaning. Reposition every two hours while in bed and offer fluids with position changes. Monitor skin daily with cares and report changes to charge nurse. Use moisturizer with cares and keep skin clean and dry. Use mechanical lift for transfers. Use incontinence pads and barrier cream to peri area as needed. Keep linen clean, dry and wrinkle free. Reposition every hour when up in chair. Increase protein in diet as appropriate and dietary consult as needed. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider progress note dated 3/20/24, indicated R13 had a stage 2 pressure injury (open wound that affects both the top and bottom layers of the skin) of sacral region (large triangular bone at the base of the spine). The open area on left sacrum was 1.8 centimeter (cm) x 1 cm x 0.2 cm. Adjacent to this wound is a pinpoint open area. Drainage is minimal and green. Edges are well defined and slightly macerated (skin is soft, wet or soggy to the touch and can delay wound healing). Right sacrum 1.2 cm x 0.2 cm x 0.1 cm think slit. No drainage and no odor. Will change treatment to cleansing with acetic acid 0.25%, skin prep to the intact periwound skin, applying calcium alginate AG (wound dressing that can absorb large amounts of exudate and has antimicrobial properties) to the wound bed and cover with a gentle adhesive foam dressing changing every other day or sooner if needed. Patient does rely on nursing staff for her repositioning and toileting needs. She does not have an air mattress on her bed at this time as she has a lip mattress. Staff are looking at options to apply an air overlay. Review of Skin Problems notes: 3/13/25: Right buttock skin is intact and within normal limits. Left buttock abrasion, scant drainage present, wound bed is 100% red, granulating tissue measuring 1.2 cm x 0.8 cm by 0.2 cm. Macerated tissue measuring 0.2 cm by 0.2 cm. Provider notified. 3/14/25: Abrasion to the left buttock continues to be open with a small 0.3 cm by 0.5 cm abrasion right below the current abrasion. 3/15/25: Abrasions x 2 to left buttock area. Area cleansed and dressing applied as ordered. Right buttock skin starting to slough, at this time is not open and cream was applied. 3/19/25: Dressing change to abraised [sic] tissue to left inner buttock completed. Small abraised [sic] tissue noted on 3/14/25 below current abraised [sic] site remains apparent. Also has abraised [sic] tissue to right inner buttock measuring approximately 0.2 cm x 0.2 cm. Physician notified of changes. 3/20/25: See provider note (above). 3/22/25: Left and right inner buttock/sacrum; previous dressing soiled and removed to be changed. Moderate purulent drainage present on dressing. Wound appears light red, granulating tissue present. On observation 3/24/25 at 12:10 p.m., R13 was seated in her Broda (positioning chair) chair in the dining room. R13 was being assisted by staff with meal. On observation 3/25/25 at 8:44 a.m., R13 was seated in her Broda chair and was assisted from the dining room back to her room after breakfast by nursing assistant (NA)-A. At 8:45 a.m., R13 with assist from NA-A, and NA-B and a mechanical lift, was placed in her bed and positioned on her right side. NA-A and NA-B stated R13 is repositioned every two hours. NA-A and NA-B did not check R13's pad at this time. R13's bed did not have an air mattress or overlay present. Continuous observation including interviews, was started 3/25/25 at 8:45 a.m.: 9:15 a.m. R13 remains on her right side asleep. No staff into room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:43 a.m. R13 remains on her right side. No staff into room. 10:20 a.m. R13 remains in the same position with no staff entering the room. 10:46 a.m. R13 continues on her right side. No staff entered the room. 11:09 a.m. no change in position. Laundry staff entered room to put laundry away and activities staff changed the calendar in the room. 11:30 a.m. R13 continues on her right side. No staff into room. At 11:32 a.m. activities assistant (AA)-A looked into R13's room and stated R13 usually comes to sensory class at 11:00 a.m. but didn't come this morning. 11:38 a.m., license practical nurse (LPN)-A stated R13 was given a suppository this morning around 9:45 a.m. so they didn't get her up for sensory class. 11:54 a.m. no change in R13's position and no staff into the room. On observation and interview 3/25/25 at 12:00 p.m., NA-A and LPN-A entered the room. NA-A stated she was unsure if R13 had been repositioned since she assisted with putting her to bed as she isn't working R13's hallway. NA-A and LPN-A checked R13's pad. Stool was present and was smeared onto sacral dressing that was present on left sacral area. LPN-A after cleaning up stool, removed sacral dressing and stool was present under the dressing along with serosanguinous (bodily fluid with mixture of serum and blood) drainage. LPN-A cleansed wound with acetic acid 0.25% (antimicrobial properties) placed on a sterile 4x4 guaze pad, Xerofoam (sterile petrolatum-based gauze dressing used as a non-adherent dressing and promotes a moist wound environment) placed onto wound and covered with adhesive dressing. LPN-A measured wound on left sacral area which was 1.5 cm by 1.0 cm with a white spot present in the middle of the wound. LPN-A stated she was unsure what that was but the wound was improved from the last time she changed dressing. Right sacral area had no open area or abrasions present. LPN-A indicated the redness on both buttocks was from previous pressure sores that come and go. R13 with assist of mechanical lift and LPN-A and NA-A was placed in her chair and taken to dining room for lunch. R13's medication administration record (MAR) indicated (Dulcolax) Bisacodyl 10 mg suppository dose rectal daily as needed for constipation was given 3/25/25 at 7:52 a.m. On interview 3/25/25 at 1:10 p.m., LPN-A indicated the suppository was given earlier than she had initially thought and R13 should been respositioned every 2 hours. On interview 3/25/25 at 1:59 p.m., NA-C stated she had not laid R13 down in her bed so was not sure when she needed to be repositioned. NA-C confirmed she had not repositioned R13 at all this morning and stated she was alerted to R13 not being repositioned and staff are now using a reposition sheet. On interview 3/26/25 at 10:48 a.m., the director of nursing (DON) stated she would expect staff to reposition R13 every 2 hours as indicated by the care plan. The DON indicated she has initiated a paper form for reminders for staff to reposition R13 as she had been made aware of R13 not getting repositioned yesterday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Repositioning policy dated 11/19/24, included: - Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. -Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals -Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. -Positioning the resident on an existing pressure ulcer should be avoided in most situations since it put additional pressure on tissue that is already compromised and may impeded healing. - A turning/repositioning scheduled includes a continuous consistent schedule for changing the residents position and realigning the body. -Residents who are in bed should be on at least an every 2 hour repositioning schedule or as determined by assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) services were provided according to the assessed need for 1 of 1 resident (R24) reviewed for positioning and mobility. Findings include: R24's facesheet printed 3/26/26, included diagnoses of heart failure, peripheral neuropathy (nerves located outside the brain and spinal cord are damaged causing weakness, numbness and pain), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), and osteoarthritis (degenerative disease with pain and stiffness) of multiple joints. R24's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R24 was cognitively intact, had no behaviors including refusal of care and required assist of 1-2 staff for dressing and bed mobility and assist of 2 staff for toileting and transfers. The MDS included R24 has frequent pain which interferes with activities of daily living and rated pain at a level of 3 on scale of 1-10. R24's medications included opioid use, antidepressant, diuretic, hypoglycemic and antiplatet agent. R24's care plan last revised 2/26/25, indicated R24 had a self care deficit related to pain, decreased mobility, muscle weakness, and fatigue. Interventions included assist of 1-2 for dressing, and grooming. Toileting and transfer require assist of 2. Special directions included encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares (as tolerated/allowed by resident). May be completed when seated in wheelchair or when lying in bed. Report concerns/refusals to nurse. See therapy communication for additional information. On observation and interview 3/24/25 at 1:19 p.m., R24 stated staff don't do exercises with me at all. On the wall in R24's room, ROM exercises for elbows and shoulders was posted. R24 indicated she was in therapy and they ordered these exercises but no one ever helps her do them. R24 stated she does go to restorative nursing services one to two times per week and they help her do other exercises. R24 added she isn't able to do the exercises by herself as it is too painful to move her arms very far without some assistance from staff. R24's Rehab Communication form dated 1/6/25, by OT-C for nursing staff included Please complete AAROM to bilateral upper extremities with AM and PM cares as patient tolerates either seated in wheelchair or lying in bed. Exercises to complete are attached. R24's Occupational Therapy Discharge Summary for dates of service 12/10/24 - 1/6/25, signed by occupational therapist (OT)-C included discharge to current skilled nurse facility with bilateral upper body AAROM twice a day by nursing to shoulder flexion/extension, shoulder abduction/adduction, shoulder horizontal abduction/adduction for 10 reps per motion. Prognosis is good with consistent staff follow-through. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's treatment records for 1/8/25 thru 3/26/25, for encourage/assist resident to complete AAROM (active assistive range of motion) with bilateral upper extremities twice a day with morning and evening cares included 3 missed out of 77 opportunities with the initials by the nurse on duty that day completing the documentation. On interview 3/25/25 at 4:47 p.m., OT-C indicated R24 was in therapy until 1/6/25. OT-C stated R24 is compromised in her shoulders and elbows and needs ROM one to two times a day to maintain her motion. OT-C indicated AAROM is short for active assistance range of motion meaning staff should be assisting her. On interview 3/25/25 at 4:52 p.m., R24 indicated no one did ROM with her today but she did attend restorative therapy. On interview 3/26/25 at 9:52 a.m., nursing assistant (NA)-D indicated NA's are responsible for doing ROM and R24 does her ROM exercises on her own. NA-D indicated they do not document if ROM is done or if resident refuses. On interview 3/26/25 at 9:54 a.m., NA-B indicated R24 does her ROM exercises on her own. NA-B added we will assist if she asks for help. NA-B indicated they don't document if ROM is completed or if resident refuses. On interview 3/26/25 at 9:58 a.m., registered nurse (RN)-A stated NA's are responsible to complete ROM but R24 can do her ROM exercises on her own. When asked if staff are completing the AAROM, RN-A indicated I think she is completing them or I assume it is getting done when I document it is completed. On observation and interview 3/26/25 at 10:13 a.m., R24 was dressed and seated in her wheelchair in her room. R24 stated she needs staff to help her with her exercises and she is unable to do them without assistance. R24 demonstrated she could lift her arms approximately 2 inches without assistance and discomfort. R24 added they have done ROM on her once since January when it was ordered. R24 indicates staff never offer, never do the exercises with her when assisting her to get dressed and thinks staff just don't care. On interview 3/26/25 at 10:44 a.m., the director of nursing (DON) stated if it is on the treatment record I would expect the nurse prior to documenting completion to check with the NA's to ensure it was offered and completed or check with the resident to ensure staff are completing it. The DON indicated she would expect the NA's to be completing this with the resident per therapy recommendations. Facility Range of Motion Exercises policy dated 12/10/24, included: -Review the resident's care plan to assess for any special needs of the resident. -Be gentle with the resident and do not rush the procedure. -If the resident becomes weak, or complains of pain, cease the exercise and summon the staff/charge nurse. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Support the extremity at the joint as it is being exercised. -Move each joint through its range of motion three times unless otherwise instructed. -Move each joint gently, smoothly and slowly through it range of motion -Remember to stop an exercise before the point of pain. -Documentation should include the date and time performed, name and title of the individual who performed the procedure, the type of ROM exercise given, whether the exercise was active or passive, how long the exercise was conducted, if and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment, the reason why and the intervention taken. The signature and title of the person who is record this data.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42073 Based on observation, interview and document review, the facility failed to ensure dish machine chemical sanitization solution was monitored to ensure dishes were properly sanitized. In addition, the facility failed to ensure temperatures were monitored in 1 of 2 kitchen freezers and 1 of 3 refrigerators (coolers). This had the potential to affect all 36 residents who resided in the facility. Findings include: Initial kitchen tour was conducted on 3/24/25 at 10:38 a.m., with cook (C-A) and dietary manager (DM)-A. Informed during the tour that the dish machine used chemicals for disinfection (low temperature dish machine). No chemical monitoring logs were visible in or around the dish machine area. Dietary aide (DA)-A was asked to provide the logs. The logs were in a binder on the other side of the kitchen. The paper logs indicated chemical monitoring was done very infrequently. A document titled Dish Machine Temperature & Sanitization Record indicated water temperature and sanitation solution was to be monitored daily with each of the three meals. Results were as follows: -- March 2025: chemical disinfectant had been tested 6 out of 69 opportunities. -- February 2025: 25 out of 84 opportunities -- January 2025: 26 out of 93 opportunities -- December 2024: 11 out of 93 opportunities -- November 2024: 1 out of 90 opportunities -- October 2024: 7 out of 90 opportunities -- September 2024: no documentation -- August 2024: no documentation -- July 2024: no documentation -- June 2024: 1 out of 90 opportunities -- May 2024: 6 out of 93 opportunities DA-A stated he was aware the disinfectant solution and temperature should be monitored and documented with each meal service, but did not have an explanation for why it had not been done. DM-A, who was new to the role, was unaware it had not been monitored. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/24/25 at 12:55 p.m., C-B was operating the dish machine. Using a chemical test strip, C-B tested the disinfectant solution in the dish machine, which registered at an acceptable level of 50 parts per million (PPM) and the gauge on the dish machine indicated an acceptable temperature of 128 degrees Fahrenheit (F). C-B admitted he knew the temperature and sanitizing solution should be monitored, but did not have a reason why it had not been documented. C-B acknowledged monitoring the chemical solution and temperature was important to kill bacteria on dishware. FREEZER & REFRIGERATOR TEMPERATURES During the initial kitchen tour on 3/24/25 at 10:41 a.m., C-A opened the silver 2-door freezer and couldn't find a thermometer. C-A immediately obtained a thermometer and added it to the freezer. The foods in the freezer were frozen solid to the touch. Temperature logs for the 2-door silver refrigerator and 2-door silver freezer were reviewed. The temperature log was titled [NAME] Temperature Sheet and on the bottom was a section titled Freezer and Cooler Temperatures. The last time any temperature was recorded was on 1/20/25. Temperatures at that time were in acceptable temperature ranges: Silver cooler: 36 degrees F Silver freezer: 2 degrees F During an interview on 3/25/25 at 11:11 a.m., C-A stated the morning and evening cooks were supposed to document temperatures of each refrigerator and freezer and record it. C-A stated, We just weren't doing it. C-A acknowledged food needed to be maintained at correct temperatures to prevent spoiling and foodborne illness. During an interview on 3/25/25 at 11:30 a.m., DM-A acknowledged she had just started her role and had not been aware of the lack of monitoring and would correct it right away. On 3/26/25 at 12:15 p.m., the administrator was informed of kitchen findings. Facility Cleaning Dishes/Dish Machine policy dated 2021, indicated all dishware would be cleaned, rinsed and sanitized after each use. The dish machine would be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy indicated for low temperature dishwasher, wash temperature should be 120 degrees F., and 50 PPM hypochlorite (bleach). Facility Dish Machine Temperature Log policy dated 2021, indicated dishwashing staff would monitor and record dish machine temperatures to assure proper sanitizing of dishes. The director of food and nutrition services would post a log near the dish machine for the staff to document temperatures. Staff would record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition would spot check the log to assure temperatures were appropriate and staff were correctly monitoring dish machine temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Food Storage policy dated 2021, indicated food would be stored at appropriate temperatures. Temperatures for refrigerators should be between 35 to 39 degrees F. Thermometers should be checked at least two times a day. Every refrigerator must be equipped with an internal thermometer. Frozen foods must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times daily.