STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 04/09/2025

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THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and complaint survey stated on April 6, 2025 and ended on April 9, 2025. During the complaint investigation, the facility was found noncompliant with regulatory requirements.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		5/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2025

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity and individuality for 1 of 15 sampled residents (Resident #6). Failure to honor the resident's request during cares and ensure staff speak respectfully does not promote the resident's self-esteem, preserve the resident's personal dignity, and may affect the resident's psychosocial well-being. Findings include: Review of the facility policy titled "Quality of Life - Dignity" occurred on 04/09/25. This policy, dated 2018, stated, ". . . Residents shall be treated with dignity and respect at all times. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self -worth. . . . Staff shall speak respectfully to residents at all times . . . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed . . ."	F 550	Corrective Actions: On or before 5/12/2025, Nurse #21, CNA #18, and CNA #20 were counseled and re-educated by the Director of Nursing on the residents rights and the importance of honoring personal choices during care. On 4/8/2025, Resident #6 was interviewed by the Social Services Director and Administrator to understand the situation and ensure all care preferences are being followed. On 4/8/2025, CNA #20 was put on leave for further investigation of the statement made. On 04/13/2025, education related to customer service was completed by Human Resources, with CNA #20, before returning to the facility. On 4/8/2025, The Social Services Director interviewed Resident #6 for any psychosocial impact from the comment made CNA #20. On or before 5/12/2025, A care plan review and update were completed by the Director of Nursing for resident #6 to	

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F 550	Continued From page 2 Review of Resident #6's medical record occurred on all days of survey. A care plan intervention, dated 03/11/24, stated, ". . . Bladder scan every shift and PRN [as needed] per [Resident's name] request. . ." An annual Minimum Data Set (MDS), dated 03/04/25, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observation on 04/07/25 at 2:45 p.m. showed two certified nurse aides (CNAs) (#18 and #20) and a nurse (#21) transferred Resident #6 from a wheelchair into bed in preparation for a bladder scan and toileting cares. The resident requested to have the bladder scan before the start of toileting cares. The three staff members failed to honor the resident's request and continued rolling the resident from side to side and placed a new brief. While rolling the resident to the side, one CNA (#20) stated, "I am going to build muscles in my [slang word for breasts]." During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to honor Resident #6's bladder scan request and the CNA's statement during cares was "unacceptable." During an interview on 04/08/25 at 3:39 p.m., Resident #6 confirmed hearing the comment made by the CNA (#20) and stated, "I didn't think it was professional."	F 550	include the residents expressed preferences and care requests. Identification of Others: On 4/8/2025, Social Services and Resident Advocates conducted interviews with residents to determine whether any other concerns with staff language; no other concerns were identified. On or before 5/12/2025, the DON/Designee ensured Care plans for dependent residents were reviewed to ensure individual preferences and routines were clearly documented. Systemic Changes: On or before 5/12/2025, All nursing staff and CNAs were re-educated on F550 Resident Rights, with special focus on respecting and honoring resident choices, active listening and documentation of preferences, reporting barriers to honoring requests such as resident safety or medical concerns to the nurse managers. Any team member who is not educated will receive education prior to working the next shift. On or before 5/12/2025, all nursing staff and CNAs were assigned the customer service training module on Healthcare Academy. On or before 5/12/2025, the resident preference section in the care plan template was enhanced to ensure detailed documentation of specific care	

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F 550	Continued From page 3	F 550	routines (e.g., time of day, bathing choices, dining preferences, etc.). Monitoring: The DON or designee will conduct 3x weekly random observations of care delivery for at least 3 residents to ensure staff are honoring resident preferences during care for 4 weeks and then 1x weekly for 3 residents. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. Resident satisfaction interviews will be conducted by the Social Services Director, focusing on whether their choices and care requests are respected for 5 residents, 3x weekly for 4 weeks, then 1x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		5/20/25

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F 558	Continued From page 4 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to ensure reasonable accommodation of needs regarding call lights for 1 of 15 sampled residents (Resident #6). Failure to place call lights within reach may result in an inability for residents to call for help, an increased risk for falls, and discomfort. Findings include: Review of the facility policy titled "Call System, Resident" occurred on 04/09/25. This undated policy stated, ". . . Each resident is provided with a means to call staff directly for assistance from his/her bed . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included quadriplegia. The care plan stated, ". . . I use an easy call universal quadriplegic call bell [activated by a turn of the resident's head] or soft touch call bell [placed in the resident's hand] while in bed . . ." An annual Minimum Data Set (MDS), dated 03/04/25, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observations on 04/07/25 of Resident #6's call bell placement showed the following: * 2:55 p.m. and at 3:07 p.m., a nurse (#19) exited the resident's room and failed to place the call bell within reach. The call bell laid in the seat of the wheelchair. * 3:30 p.m., a certified nurse aide (CNA) (#20)	F 558	Corrective Actions: On 5/12/25, a sign was placed in the room of resident #6 by the assistant director of nursing. On 5/12/25, resident #6 was encouraged to remind staff to check call light placement. On 5/12/25, education was provided to Nurse #19 and CNA #20 by the director of nursing on correct call light placement Identification of Others: On 5/12/25, a full audit of all residents rooms was conducted to ensure call lights were within reach for each resident, particularly those who are dependent or have mobility impairments, by the Administrator. No concerns were identified. Systemic Changes: On or before 5/12/25 all staff received mandatory re-education on call light protocol, including ensuring call lights are in reach before leaving a residents bedside by the Director of nursing or designees. Monitoring: The DON or designee will conduct random weekly audits for call light	

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F 558	Continued From page 5 exited the resident's room and failed to place the call bell within reach. The call bell remained in the seat of the wheelchair. * Approximately 4:05 p.m., a CNA (#20) clipped the easy call universal quadriplegic call bell to the resident's pillowcase adjacent to his head and left shoulder and exited the room. The resident was unable to reach the call bell for activation with his head. When asked how often staff fail to leave a call bell within reach or accessible to him, Resident #6 stated, "more often than not." During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to place the call bell within the resident's reach and ensure the resident can activate it.	F 558	placement 5x weekly for 4 weeks, then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 15 sampled residents (Residents #4, #26, and #36). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include:	F 641	Corrective Actions: On or before 5/20/2025, accurate coding of A1510 for serious mental illness for resident #26 was completed to ensure accurate coding to reflect PASSR. Accurate device coding in H0100 as suprapubic catheter for resident #36. Correct MDS submitted on 4/8/25 On or before 5/12/25, the indication of Carbidopa-Levodopa for resident #4 was updated to reflect the physician's diagnosis of Parkinsonism. MDS verified to match.	5/20/25

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F 641	Continued From page 6 SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2024, page A-32, stated, ". . . Coding Instructions. Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." Review of Resident #26's medical record occurred on all days of survey. The record included diagnoses of psychosis, schizotypal disorder, bipolar disorder and psychophysical visual disturbances. A comprehensive MDS, dated 06/17/24, showed the facility failed to code Section A1510 for a serious mental illness. During an interview on 06/25/25 at 1:18 p.m., an administrative nurse (#1) confirmed staff failed to accurately code section A on Resident #26's MDS. SECTION H: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-3, stated, "H0100: Appliances (cont.) Coding Tips and Special Populations. Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only . . ." Review of Resident #36's medical record occurred on all days of survey and identified a supra pubic catheter. A physician's order, dated 02/03/25, stated, "Indwelling Catheter . . ." The quarterly MDS, dated 02/11/25, Section H0100 included coding for both an indwelling catheter and an external catheter.	F 641	Identification of Others: On or before 5/12/25, audit of all residents in house with catheters, major psychiatric diagnosis, and Parkinsons disease for accurate coding of MDS. On or before 5/12/25, CNA documentation of catheters was assessed for accuracy. Systemic Changes: On or before 5/12/25, education was provided to current MDS coordinators both in-house and remote on accurate MDS assessment completion. Monitoring: MDS/designee to monitor for accuracy all MDS submissions with catheters, major psychiatric diagnoses, and Parkinsons diagnosis prior to submission. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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F 641	Continued From page 7 During an interview on 04/08/25 at 2:06 p.m., a corporate staff member (#15) confirmed staff failed to accurately code section H on Resident #36's MDS. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, page I-8, stated, ". . . Active Diagnoses . . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . . . medical treatments . . . during the 7-day look-back period . . ." Review of Resident #4's medical record occurred on all days of survey. A provider note, dated 02/11/25, identified a diagnosis of Parkinson's Disease and a new medication order for carbidopa-levodopa used to treat symptoms of the disease. The quarterly MDS, dated 03/17/25, failed to include an active diagnosis of Parkinson's disease. During an interview on 04/09/25 at 11:15 a.m., an administrative nurse (#1) confirmed staff failed to accurately code section I on Resident #4's MDS.	F 641		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		5/20/25

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F 677	Continued From page 8 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 6 of 15 sampled residents (Resident #2, #6, #16, #36, #43, and #47) dependent on staff assistance for personal hygiene and dining. Failure to assist residents who cannot perform personal hygiene, position self, or open items at meals may result in poor hygiene, skin issues, weight issues, and decreased self-esteem. Findings include: Review of the facility policy titled "Fingernails/Toenails, Care of" occurred on 04/09/25. This policy, dated 2018, stated, ". . . The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. . . ." Review of the facility policy titled "Activities of Daily Living (ADLs), Supporting" occurred on 04/09/25. This policy, dated 2021, stated, ". . . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, . . . including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, nail care and oral care) . . . Dining (meals and snacks) . . ." - Review of Resident #2's medical record occurred on all days of survey. The current care plan identified, ". . . has ADL self-care deficit as evidenced by decreased mobility related to paraplegia . . ." Observation on 04/06/25 at 1:46 p.m. showed	F 677	Corrective Actions: On 4/8/25 residents # 2, 6, 16, 36, 43, 47 received immediate nail care from nursing management. On 4/9/25 resident #43 nail polish was removed by assistant director of nursing and nails were trimmed and painted per resident preference. On 4/8/25 oral care was provided to residents #36 and #47 by their assigned CNAs. On 4/9/25 Staff member #9 was identified and educated on the appropriate use of items labeled for residents by assistant director of nursing. On 4/9/25 Resident # 47 and roommate had unlabeled oral care items removed and labeled items were provided for both residents by central supply manager. On 4/8/25 staff members #3, 4, 5,6 were educated by the Director of Nursing on how to appropriately assist residents with meal setup which included the appropriate position of the resident in bed or chair with consideration for physical or neurological deficits. On 4/9/25 Resident #36s care plan was reviewed by the Director of Nursing to ensure that it reflected assistive needs with meals. On or before 5/12/25 task schedules were reviewed for residents # 2, 6, 16, 36, 43, and 47 and revised to include routine nail cares by the Director of Nursing. On or before 5/12/25 careplans and task lists were reviewed by the Director of Nursing to confirm the need of assistance	

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F 677	Continued From page 9 Resident #2 had long, thick, yellow toenails. The resident stated, "I need someone else to cut them [toenails], it's been a while since they have been done." - Review of Resident #6's medical record occurred on all days of survey. The care plan identified dependent on staff for personal hygiene. Observation on 04/07/25 at 10:15 a.m. showed Resident #6's toenails on both feet approximately one-fourth inch in length. During an interview on 04/07/24 at 2:36 p.m., Resident #6 stated facility staff clip his/her toenails "occasionally." During an interview on 04/08/25 at 1:34 p.m., an administrative staff member (#16) agreed Resident #6's toenails needed trimming. - Review of Resident #16's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated 03/31/25, identified moderate assistance required for personal hygiene. Observation on 04/06/25 at 2:25 p.m. showed Resident #16's fingernails extended beyond her fingertips. The resident stated, "The nurse was going to cut them today but hasn't yet. They cut them about every two to three weeks." Observation on 04/07/25 at 3:27 p.m. showed Resident #16's fingernails remained untrimmed and dirty under the nails. - Review of Resident #36's medical record occurred on all days of survey. Diagnoses	F 677	with oral care and the delegation to complete and document to CNAs. Identification of Others: A facility-wide audit was conducted on 5/12/25 by the Director of Nursing to identify all residents requiring assistance with meal set-up and ensured careplans reflected needs. Task lists audited on 5/12/25 by the Assistant Director of Nursing to ensure oral cares and nail cares are in place to be documented on. Oral care was present, but nail care was not. This has been added to the bathing task. Systemic Changes: On or before 5/12/25 all CNAs were educated on nail care protocols by the Director of Nursing. On or before 5/12/25 all CNAs were educated on repositioning frequency and documentation by the Director of Nursing. On or before 5/12/25 all CNAs were educated on meal set-up assistance protocols by the Director of Nursing. On 5/12/25 nail care was added to the bathing task for CNAs to be assigned and documented for all residents. Starting on 5/12/25 all personal hygiene basins, toothbrushes, etc. will be labeled when brought to the resident room. Items will be routinely replaced by the central supply manager. Monitoring:	

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F 677	Continued From page 10 included hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness) following a stroke affecting the right dominant side. A quarterly MDS, dated 02/11/25, identified Resident #36 required ADL setup assistance for eating and dependent on staff for oral cares and personal hygiene. The current care plan stated, ". . . should be upright in wheelchair for all meals to decrease risk for aspiration/choking. . . . should receive consistent oral cares. . . . I have physical functioning deficit . . . Personal hygiene: mod [moderate] A [assistance] . . . Eating: set up A, sitting up in w/c [wheelchair] during meals. Review of Resident #36's oral hygiene charting, dated March 9 - April 7, 2025 (30 days), identified staff provided oral cares one time a day for 12 days, two times a day for 12 days, and three times a day for six days. Observations of Resident #36 showed the following: * 04/07/25 at 8:49 a.m., seated in a wheelchair in his room and leaning to the left. A dietary staff member (#3) delivered the resident's breakfast tray and sat the tray on the bedside table in front of the resident but to his right side. The resident could not reach the items on the tray due to his inability to use his right arm and hand. * 04/07/25 at 12:06 p.m., seated in a wheelchair in his room and leaning to the left side with his left arm pressed against the wheelchair armrest. The resident stated an aide washed his face, but did not brush his teeth this morning. The resident stated staff do not help him brush his teeth "with	F 677	The DON or designee will conduct weekly audits of 5 residents nail cares provided 3x weekly for 4 weeks then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will conduct weekly audits of 5 residents oral cares provided 3x weekly for 4 weeks then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will conduct weekly audits of 5 residents proper positioning provided 3x weekly for 4 weeks then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will conduct weekly audits of 5 residents meal set up provided 3x weekly for 4 weeks then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality	

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F 677	Continued From page 11 any regularity and have not yet today." Observation showed small yellow particles below his right eye and a brown dried substance on the corner of the left side of his mouth and down his chin. A sign above the bed stated, "PLEASE!! complete oral care (brush teeth) after every meal, morning, and night. Thank you!" At 12:08 p.m., a certified nurse aide (CNA) (#4) arrived with the resident's lunch tray, placed it on the bedside table, and removed the breakfast tray. The CNA failed to assist Resident #36 with hand hygiene or setup the resident's lunch tray. With his left hand, the resident tried to move the tray closer to him and attempted to open the milk carton. Observation showed his fingernails dirty with brown debris underneath them. The resident was able to get his right thumb into the top of the milk carton but failed to open it. The resident stated staff open the milk carton about half the time. The resident opened the milk carton about 20 minutes later by sticking his second and third fingers inside the milk carton. At 1:42 p.m., Resident #36 agreed to call for assistance when, after five minutes, he failed to remove a plastic cover from a dish of fruit. * 04/08/25 at 8:31 a.m., a nurse (#5) and a CNA (#6) repositioned Resident #36 in bed. The CNA raised the resident's head of the bed to 45-60 degrees, set up his breakfast tray, and opened the milk and yogurt cartons. The resident had difficulty reaching the items on his meal tray. At 09:02 a.m., the resident had not started to eat and stated, "It would be good to sit up a little higher" but he didn't want to call staff. An unidentified CNA arrived to assist the resident with cares, but the resident stated he would like to eat first. The unidentified CNA exited the room	F 677	Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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F 677	Continued From page 12	F 677		

and failed to assist the resident with positioning and set up with his meal. At 9:14 a.m. (43 minutes after receiving the meal tray) this surveyor requested assistance for the resident and a CNA (#6) called for another staff member to assist her to position the resident.

- Review of Resident #43's medical record occurred on all days of survey. The current care plan stated, "I have physical functioning deficit . . . Personal Hygiene: A x 1 [assistance of one staff] . . ." An activities' note, dated 02/26/2025 at 10:30 a.m., stated, "1:1 [one to one] pamper and polish."

Observation on 04/07/25 at 8:39 a.m. showed Resident #43's fingernails with dark colored debris under the end of the nails and at least half of the purple nail polish worn off the resident's left hand and no polish on the right hand.

During an interview on 04/09/25 at 8:57 a.m., a CNA (#7) stated the CNAs provide resident cares and baths. "The bath includes looking at their nails and clipping them as needed."

- Review of Resident #47's medical record occurred on all day of survey. The current care plan stated, ". . . I have impaired physical functioning related to: . . . L [left] sided weakness, impaired cognition . . ."

Observations for Resident #47 showed:
* 04/06/25 at 4:30 p.m., teeth with a yellow-brown looking substance and white crust on the corners of mouth and fingernails on both hands long with a dark substance underneath the nail bed. An unlabeled basin containing a toothbrush was

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F 677	Continued From page 13 observed by the sink, and the other resident in the room identified the basin as "mine." * 04/09/25 at 8:18 a.m., two CNA's (#8 and #9) assisted the resident with morning cares. The CNA (#9) assisted the resident to sink, could not locate a basin or toothbrush, and took a basin and toothbrush out of the roommates drawer with the roommates name written on the basin. The surveyor asked the CNA to identify the name on the basin. CNA (#9) stated, "oh my mistake," and obtained a new basin and toothbrush for Resident #47. *04/09/25 at 10:50 a.m., observed an unlabeled basin containing a toothbrush on the sink in Resident #47's room. The CNA (#9) failed to label the basin. During interviews on 04/09/25 at 10:30 a.m. and 12:05 p.m., an administrative nurse (#1) stated she expected the CNAs to assist dependent residents with all ADLs.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and resident and staff interviews, the facility	F 684	Corrective Actions: On 4/8/2025, a skin check was completed	5/20/25

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F 684	Continued From page 14 failed to provide the necessary care and treatment for 1 of 3 sampled residents (Resident #6) with impaired skin integrity and concerns of incontinence care. Failure to assess, monitor, and treat skin issues in a timely manner may have resulted in a delay of treatment and risk for further skin breakdown. Failure to provide routine incontinence cares (check and change) placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, and urinary tract infections. Findings include: Review of the facility policy titled "Skin Breakdown-Clinical Protocol" occurred on 04/09/25. This policy, dated 2022, stated, "Evaluation and Recognition. . . . the nurse shall describe and document/report the following . . . Full assessment including skin breakdown location, stage if applicable, length, width and depth . . . current treatments . . ." The facility failed to provide a policy on the process/frequency of incontinence cares for residents who require check and change. Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, "Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . . . also contribute to skin excoriation [area of loss of the superficial layers	F 684	by the Assistant Director of Nursing for resident #6. The provider was notified by the Assistant Director of Nursing on 04/08/2024 for resident #6 skin concerns, and no new orders were given. Monitoring orders placed for areas of concern. On or before 05/12/2025, incontinence care routines were reviewed and updated by the Director of Nursing for resident #6 to ensure timely provision. On or before 05/12/2025, incontinence care plans were reviewed by the Director of Nursing to reflect current needs, risk factors, and interventions. Identification of Others: On 4/8/2025, all residents were immediately assessed for skin integrity by the Director of Nursing and Wound Nurse. On 4/8/2025, appropriate wound care treatments were initiated per physician orders for residents identified. On or before 05/12/2025, incontinent care routines were reviewed by the Director of Nursing. Systemic Changes: On or before 05/12/2025, all licensed nurses and CNAs to receive re-education on the facility's skin assessment protocol and incontinence care policy by the Director of Nursing or Designee. Any licensed nurse or CNA not educated will receive education prior to working next shift.	

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F 684	Continued From page 15 of the skin] . . . Any accumulation of secretions . . . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Page 1221 stated, "Managing Urinary Incontinence . . . attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . . ." Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 03/10/23, stated, "Weekly Skin Assessments . . . every Wed [Wednesday] . . ." The care plan stated, ". . . has potential for altered skin integrity due to immobility and incontinence . . . conduct weekly skin inspection . . . I have a physical functioning deficit related to: limited mobility . . . Bed Mobility - Assist x3 [times three staff] . . . Toilet Use-Check and change assist x2 for pericares . . . Alteration in elimination of bowel and bladder r/t [related to] incontinence . . . History of recurrent UTI [urinary tract infections] . . ." An annual Minimum Data Set (MDS), dated 03/04/25, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observation on 04/07/25 at 10:15 a. m. identified a purple circular area to the outer area/pad of the fifth toe on the left foot approximately a half inch in size, and red circular abrasion-type areas with a white open pin dot in the centers of the red areas located on the distal joints of the 1st, 2nd, 3rd and 4th left foot toes and the 2nd and 3rd toes of the right foot. An observation with an administrative nurse (#16) occurred on 04/08/25 at 1:34 p.m. The nurse (#16) confirmed the wounds to Resident #6's toes/feet.	F 684	On or before 5/20/2025, routine incontinence care schedules were reviewed and standardized for all shifts by the Director of Nursing. On or before 5/12/2025, CNAs were educated on proper documentation of care provided by the Director of Nursing. Any CNA not educated will receive education prior to working next shift. Monitoring: The DON or designee will conduct weekly audits of completion of skin assessments 7x weekly for 4 weeks then 3x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will audit 1 random skin assessment for accuracy 3x weekly for 4 weeks, then 1x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will audit incontinence care records for adherence to scheduled care 5x weekly for 4 weeks, then 3x weekly.	

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F 684	Continued From page 16 During an interview on 04/08/25 at 12:58 p.m., an administrative nurse (#16) stated staff nurses complete and document the residents' weekly head to toe assessments. When a wound is identified, the nurses document it on the treatment administration record (TAR), and the wound nurse completes/documents measurements and weekly reviews. Review of Resident #6's weekly skin assessments lacked identification/documentation of the left and right toe/foot skin breakdown. Review of the resident's TAR and physician's orders failed to include monitoring and treatment of the toes/feet. During an interview on 04/06/25 at 3:56 p.m., Resident #6 stated the following: * "Day [shift] will change me at the end of their shift [shift ends a 6:00 p.m.], and I won't get changed again until 11 [11:00 p.m.] or 12 [12:00 a.m.]." * "The times I do put on my light [call bell] to be changed, they [staff] say, 'I will see if I can find somebody.' Then I get super soaked and they end up having to do a bed change and have to roll me around in bed." * "I tend to be a heavy wetter." Review of Resident #6's check and change documentation record, dated March 9 through April 6, 2025, identified the following: * Thirteen days, check and change completed once in 24 hours * Eleven days, check and change completed twice in 24 hours * Four days, check and change completed three	F 684	The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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F 684	Continued From page 17 times in 24 hours * One day, check and change completed four times in 24 hours.	F 684		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #47) with weight loss. Failure to monitor/document intakes accurately and provide encouragement and assistance with meals and supplements resulted in a significant weight loss.	F 692	Corrective Actions: On 5/5/2025, MA #12 educated on correct documentation and waiting with resident and encouraging them to finish supplement by the Director of Nursing. On 05/13/2025 resident #47 expired. On 5/5/2025, the 5 CNAs who documented on resident #47s intake was	5/20/25

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F 692	Continued From page 18 Findings include: Review of the facility policy titled "Weight Assessment and Intervention" occurred on 04/09/25. This policy, dated September 2008, stated, ". . . The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. . . . 3. The Dietitian will review the weight record weekly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. Provider will be updated with significant weight changes. . . . Analysis . . . 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: . . . b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake . . . Interventions for undesirable weight loss shall be based on careful consideration of the following: a. Resident choice and preferences b. Nutrition and hydration needs of the resident c. Functional factors that may inhibit independent eating . . . f. Medications that may interfere with appetite, chewing, swallowing, or digestion . . . g. The use of supplementation . . ." - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included diabetes and malnutrition. Physician's orders identified Mounjaro (a medication to lower blood sugar that may also cause weight loss) weekly on Fridays, Boost (liquid supplement) three times (TID) (8:00 a.m., 2:00 p.m., and 8:00 p.m.) and as needed (PRN) for malnutrition, and a regular diet, easy to chew texture, thin consistency.	F 692	all educated on correct documentation and waiting with the resident and encouraging them to finish their meal as well as to offer alternatives by the Director of Nursing. Identification of Others: On 5/12/2025, the Director of Nursing or designee audited the weights for all residents in the facility for the last 30 days to ensure there were no previously unidentified significant weight loss. No concerns were identified. On 5/12/2025, an audit was completed by DON to ensure all current residents with significant weight loss have had a recent evaluation by the Registered Dietitian and interventions were in place as recommended and care planned. No concerns were identified. On or before 05/12/2025, the Director of Nursing or designee audited all current resident careplans to identify all residents with the need for assistance to ensure residents are receiving assistance with meals. On or before 5/12/2025, the resident advocates completed a new food and beverage preference assessment was completed on all residents in-house. Systemic Changes: On or before 05/12/2025, all nursing staff and CNAs were re-educated on the accuracy of documentation of intake by the Director of Nursing.	

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F 692	Continued From page 19 The current care plan stated, ". . . I have impaired physical functioning . . . Eating: supervision for meals . . . Potential for or presence of altered nutrition needs altered ability to feed self . . . requires mechanically altered diet, impaired cognition . . . Diet and food texture provided as ordered . . . Encourage food and fluid intake . . . Record % [percent] of meals consumed . . . " An addition to the care plan on 03/06/25 stated, "I have weight loss r/t [related to] loss of appetite, eating < [less than] 50% of meals, potential medication side effects, disinterest in food/meals . . . Dietitian consult for caloric, hydration and nutritional intake needs, with recommendations for increased caloric needs . . . Offer high calorie/nutrient dense supplements as ordered by physician/dietitian . . . Weekly weights as ordered by physician . . . " A review of Resident #47's weight record identified the following: *12/27/24 (admission) 188 pounds *01/26/25 173 pounds (7% weight loss in one month) *03/23/25 169 pounds (10% weight loss in three months) *04/06/25 150 pounds (11% weight loss in two weeks and a 20% weight loss since admission) Observation of Resident #47 occurred on 04/07/25 and showed the following: *9:00 a.m., staff assisted Resident #47 with the morning meal in the dining room. The resident refused the meal and drank half a glass of juice. The meal intake record identified the resident consumed 25-50% of the morning meal which differed from the observation.	F 692	On or before 05/12/2025, dietary staff educated on the accuracy of documentation of intake by the Director of Nursing or designee. A new process is in place to have dietary members write down percentage eaten when tray is removed and give to CNAs to chart. Both CNAs and dietary staff were educated by the Director of Nursing or designee on or before 05/12/2025. The clinical team to review meal intake triggers on clinical dashboard on PointClickCare software and will discuss at skin and weight meeting after determining need for immediate follow up. CNAs and/or Dining staff to first offer alternative meal items from the always available menu to residents who refuse. CNAs and/or dining staff will offer different flavors of supplements to residents if they refuse and if continues to refuse update nurses with refusal of meals/supplements so provider can be updated. Will also update the Registered Dietician for alternate supplements to be considered. Monitoring: The DON or designee will conduct 5x weekly random observations of meal/supplement intake and compare them to CNA charting for at least 3 residents for 4 weeks and then 1x weekly for 3 residents. The results of the audits will be tracked	

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F 692	Continued From page 20 *10:30 a.m., a medication aide (MA) (#12) brought the scheduled 8:00 a.m. Boost to the resident's room, placed it on the overbed table, and failed to provide assistance/encouragement to drink it. *11:55 a.m., a full glass of Boost remained on the resident's overbed table. *12:20 p.m., the MA (#12) confirmed the Boost on the overbed table as the 8:00 a.m. supplement. Review of the medication administration record (MAR) identified the resident consumed 25% of the 8:00 a.m. Boost which differed from the observation of a full glass of Boost . An unidentified certified nurse aide (CNA) confirmed Resident #47 refused lunch, and two glasses of juice were noted on the overbed table. *3:45 p.m., a full glass and one half glass of juice, and a full glass of the 8:00 a.m. Boost remained on the overbed table in the same position as earlier. *5:00 p.m., a staff member took Resident #47 to the dining room. A full glass and another half glass of juice and the full glass of Boost remained in in the same position as earlier on the resident's overbed table. *5:05 p.m., Resident #47 seated alone at the dining room table. The paper menu in front of the resident stated, "doesn't want to eat." The resident's meal included a scoop of ham salad, creamed carrots, glass of juice, and two gelatin cups. Staff failed to offer assistance or alternative menu items to Resident #47 during the meal. *5:40 p.m., an unidentified dietary staff member cleared the table, and stated Resident #47 "was done eating." The resident ate one spoonful of ham salad, no carrots, one spoonful of gelatin, and drank the juice. Review of Resident #47's	F 692	and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. The DON or designee will audit to ensure the Registered Dietician recommendations are completed on residents with loss and followed in skin and weight meeting weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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	355024	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 21	F 692		

meal intake identified the resident consumed 51-75% of evening meal which differed from the observation.

Observation of Resident #47 on 04/08/25 showed the following:
*8:52 a.m., Resident #47 sat alone at the dining room table with a glass of juice three-fourths full. An unidentified dietary aide stated, "[Resident name] refused his meal and did not eat."
*11:55 a.m., the resident sat in a wheelchair in his room. A nurse (#5) called a CNA on the walkie talkie and asked if the resident ate. The CNA responded, "He refused, we asked him a couple of times." Another CNA in the hall said, "He never eats." Observation showed two boxes of Boost (one opened and full and the other unopened), and a full glass of juice on the resident's overbed table. Review of the MAR identified the resident consumed 50% of the 8:00 a.m. Boost supplement which differed from the observation.
*5:19 p.m., Resident #47 rested in bed. When asked if he was going to eat the resident replied "No." Two boxes of Boost and a glass of juice remained on the bedside table as in prior observations. Review of the resident's meal intake identified staff documented 25-50% of the supper meal consumed; however, Resident #47 refused his meal. Review of the MAR identified the resident consumed 25% of the 2:00 p.m. Boost which differed from the observation.

The MAR showed Resident #47 did not receive any PRN Boost on all days of survey.

The "Weekly Skin and Nutrition IDT [interdisciplinary team] Review," dated 03/27/25,

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F 692	Continued From page 22 identified a significant weight change of 10%. This assessment stated, "Not eating well. Main intakes are supplements. Weight is stable over the past month. No new weight over the past week. . . . Averaging 25-50% at meals . . . Diet: Regular . . . Supplements: Boost TID . . . Assistance/independence at meals: 1:1 [one to one] . . . Plan: Follow intakes and weight. No new weight this week. Will continue POC [plan of care]. Continue with Boost TID. Okay to drink supplement at meals if intakes poor. . . ." A nutrition/weight progress note on 04/03/2025 stated, "Skin/Weight team met today to discuss resident. Resident continues to refuse food and prefers boost shakes, will continue to monitor per policy. Provider and resident updated." Resident #47's medical record lacked a dietitian's evaluation for the significant weight loss and current interventions or additional interventions to prevent further weight loss. The care plan failed to reflect the change to 1:1 assistance at meals as defined by the IDT. During an interview on 04/09/25 at 10:30 a.m., an administrative nurse (#1) stated she expected staff to accurately document meal intakes and observe and document percentage of supplements taken.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		5/20/25

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F 812	Continued From page 23 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen. Failure to ensure dishware is stored in a clean area and failure to ensure the floors and warewashing machine are free from food/dust debris has the potential for contamination of food and may result in a foodborne illness to residents, visitors, and staff. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, reviewed 01/08/25, Chapter 4-6, pages 20-21, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, " (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. . . . (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an	F 812	Corrective Action: The Dietary Manager cleaned the loose debris and dust that had accumulated on the top of the mechanical ware washing machine on 4/9/2025. The Dietary Manager cleaned the visible dry particles and debris that were identified on a tray of uncovered bowls located in a high-traffic area of the kitchen on 4/9/2025. The Dietary Manager cleaned the visible dry food/debris that was identified on the bottom of a cart used to store clean dishware on 4/9/2025. The Dietary Manager cleaned the accumulation of food/dirt debris that was identified on the floor between the table legs of a stainless-steel counter and the wall in the dishwashing room on 4/9/2025.	

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F 812	Continued From page 24 accumulation of dust, dirt, FOOD residue, and other debris." Observations on 04/09/25 at 10:30 a.m. showed the following in the main kitchen: * Loose debris and dust accumulated on the top of the mechanical warewashing machine. * Visible dry particles and debris on a tray of uncovered bowls located in a high traffic area of the kitchen. * Visible dry food/debris on the bottom of a cart used to store clean dishware. * An accumulation of food/dirt debris on the floor between the table legs of a stainless-steel counter and the wall in the dishwashing room. During an interview on 04/09/25 at 10:30 a.m., a dietary staff member (#3) confirmed the kitchen environment and floors should remain clean.	F 812	Identification of Others: On 4/10/2025, the Dietary Manager ensured there was no loose debris, dust, or food particles on any surface to include the floor. Systemic Changes: All dietary staff members were educated on or before 5/12/2025 on the 2022 Food and Drug Administration (FDA) Food Code, Chapter 4-6, pages 20-21, Section 4-601.11 stating, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and utensils, stated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch &. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Monitoring: The Dietary Manager/Designee will monitor the kitchen for overall cleanliness 5 x weekly for 2 weeks; then 3 x weekly for 2 weeks; then 1 x weekly for 4 weeks to ensure cleanliness is maintained. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	
F 880	Infection Prevention & Control	F 880		5/20/25

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F 880 SS=E	Continued From page 25 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 880		

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F 880	Continued From page 26 infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 8 sampled residents (Resident #2, #6, #8, #36, and #50) and one supplemental resident (Resident #15) observed during cares. Failure to	F 880	Corrective Actions: Nurse #11, Nurse #13, and Nurse #5 were re-trained on EBPs, including when and how to use gloves, gowns, and other PPE and hand hygiene as per CDC and CMS guidelines on or before 5/5/2025 by	

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F 880	Continued From page 27 practice infection control standards related to enhanced barrier precautions (EBP), perineal care, dressing changes, and hand hygiene, has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 04/09/25. This undated policy stated, ". . . EBPs employ targeted gown and glove use during high contact care activities . . . Examples of high-contact care activities requiring the use of gown and glove for EBP include . . . urinary catheter . . . wound care (any opening requiring a dressing). . . ." Review of the facility policy titled "Dressings, Dry/Clean" occurred on 04/09/25. This undated policy stated, ". . . Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. . . ." Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 04/09/25. This undated policy stated, ". . . Use an alcohol-based hand rub or . . . soap and water for the following situations: . . after contact with resident's intact skin; j. After contact with blood or body fluids; k. After handling used dressings . . . After removing gloves . . ." Findings include: ENHANCED BARRIER PRECAUTIONS	F 880	the Director of Nursing. CNA #6 and CNA #18 were re-educated and competency-tested on proper perineal care (including retracting of foreskin and appropriate PPE use) on 5/12/25 by the Director of Nursing. CNA #8, CNA#6, CNA #10, CNA #20, and Nurse #13 were verbally counseled and re-educated on 5/12/25 on hand hygiene protocol and proper use of gloves by the Director of Nursing. On 05/05/2025, a chart review for residents #2, #6, #8, #15, #36, and #50 by the Director of Nursing and no negative impacts were found. Identification of Others: On 5/5/2025, an audit of residents on EBP was completed by the Director of Nursing for EBP implementation, including careplans, door markers, and orders. No further concerns identified. On 5/5/2025, an audit of proper pericare provided to males with catheters was completed by the Assistant Director of Nursing. No further concerns identified. Systemic Changes: On or before 5/12/25, education to all CNAs on proper pericare procedure by the Director of Nursing or Designee. On or before 5/12/25, all nurses and CNAs must review the hand hygiene procedure with the Director of Nursing or Designee. On or before 5/12/25, all nurses educated	

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F 880	Continued From page 28 - Review of Resident #50's medical record occurred on all days of survey. The current care plan stated, "enhanced barrier precautions r/t [related to] an indwelling medical device catheter. . . ." A physician's order, dated 04/01/25, stated, "CATHETER CARE: flush Foley catheter with 30mL [milliliters] NS [normal saline] every day shift for blockage/obstruction . . ." Observation on 04/06/25 at 2:07 p.m. showed a red dot sticker on Resident #50's door frame indicating EBP and a supply container in the room containing personal protective equipment (PPE) including gowns and gloves. A nurse (#11) performed hand hygiene, applied gloves, and flushed Resident #50's foley catheter with normal saline. The nurse failed to apply a gown. - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, "enhanced barrier precautions . . ." A physician's order, dated 04/03/25, stated, "L [left] heel unstageable pressure ulcer . . . change dressing every day shift . . ." Observation on 04/06/25 at 2:18 p.m. showed a red dot sticker on Resident #8's door frame indicating EBP and a supply container in the room containing PPE including gowns and gloves. A nurse (#11) performed hand hygiene, applied gloves, removed Resident's #8's left heel dressing, and discarded the dressing. Without removing the contaminated gloves, the nurse exited the room and obtained supplies from the top of the treatment cart located outside the resident's door. The nurse (#11) removed his/her gloves, performed hand hygiene, and completed the dressing change. The nurse failed to remove	F 880	in wound dressing change technique by the Director of Nursing or Designee. On or before 5/12/25 all nurses and CNAs were educated on EBP practice by the Director of Nursing or Designee. Monitoring: Infection Control Nurse or designee will perform 3x weekly random audits of EBP implementation for 4 weeks, followed by weekly audits. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. Infection Control Nurse will perform 5x weekly observations of perineal cares for 6 weeks, then 2x weekly. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed. Infection Control Nurse or designee will perform 5x weekly hand hygiene audits for 4 weeks, then 2x weekly until resolved by QAPI. Wound Nurse or designee will perform wound care observations twice weekly for 6 weeks and then weekly. The results of the audits will be tracked	

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F 880	Continued From page 29 gloves and perform hand hygiene after removing the left heel dressing and failed to wear a gown during the dressing change. - Review of Resident #36's medical record occurred on all days of survey. The current care plan stated, "[Name of Resident #36] is on enhanced barrier precautions per physician orders r/t [related to] an indwelling medical device - foley catheter. . . ." A physician's order, dated 12/21/24, stated, "Change suprapubic catheter dressing daily . . ." Observation on 04/08/25 at 8:31 a.m. showed a red dot sticker on Resident #36's door frame indicating EBP and a supply container in the room containing PPE including gowns and gloves. A nurse (#5) performed hand hygiene, gloved, and changed Resident #36's suprapubic catheter dressing. The old dressing had a scant amount of light colored drainage. The nurse failed to apply a gown to change the suprapubic catheter dressing. HAND HYGIENE - Observation on 04/07/25 at 9:24 a.m. showed two certified nurse aides (CNAs) (#6 and #8) applied gloves and a gown to assist Resident #15 with morning cares. The CNA (#8) completed frontal perineal care, removed his/her gloves, applied clean gloves, assisted the resident to use the mechanical lift, and placed the resident onto the toilet. The CNA (#8) performed perineal cares after Resident #15 had a bowel movement, removed his/her gloves, applied new gloves, adjusted the resident's clothing, applied foot pedals to the wheelchair, and combed the	F 880	and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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F 880	Continued From page 30	F 880		

resident's hair. The CNA (#8) failed to perform hand hygiene after removing gloves and after performing perineal care.

- Review of Resident #2's medical record occurred on all days of survey. A red dot sticker on the Resident's door frame indicated EBP. The current care plan stated, ". . . [Resident name] is on enhanced barrier precautions per physician orders r/t [related to] an indwelling medical device . . . catheter . . . Don [apply] gown and gloves during high-contact resident care activities . . ."

Observation on 04/06/25 at 1:46 p.m. showed a nurse (#13) entered Resident #2's room. The nurse, without performing hand hygiene, applied gloves, removed a band aid soiled with blood from the resident's toe, and with the same gloves, obtained a new band aid from her uniform pocket, and applied it to the open wound.

The nurse (#13) failed to perform hand hygiene before applying gloves, obtained a clean band aid from her pocket with soiled gloves, and failed to remove the soiled gloves, perform hand hygiene, and apply clean gloves before applying a clean band aid to Resident #2's toe wound. The nurse (#13) also failed to apply required PPE (gown) before providing wound cares.

Observation on 04/06/25 at 1:55 p.m. showed two CNAs (#10 and #14) performed hand hygiene and applied a gown and gloves. The CNAs turned Resident #2 onto his/her side and removed the resident's brief. The CNA (#10) performed perineal care, and without changing gloves or performing hand hygiene, opened the

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F 880	Continued From page 31	F 880		

resident's top nightstand drawer, obtained a tube of barrier cream, applied it to resident's buttocks over an open area of the skin, and placed it back in the resident's nightstand drawer. The CNA (#10) removed the soiled gloves, and without performing hand hygiene, applied new gloves and bagged linen from the resident's bed.

The CNA (#10) failed to change gloves and complete hand hygiene between tasks and after completing personal resident care.

- Observation on 04/07/27 at 3:37 p.m. showed a CNA (#20) assisted two other CNAs (#9 and #18) transfer Resident #6 from a wheelchair into bed and perform incontinence and perineal cares. After cares, the CNA (#20) removed her gloves, and without performing hand hygiene, obtained the resident's water mug, attempted to open the mug cover, and touched the resident's personal water pitcher. The CNA (#20) confirmed she failed to perform hand hygiene after removing her gloves and prior to performing other tasks.

During interviews on 04/08/25 at 1:08 p.m. and 04/09/25 at 11:25 a.m., an administrative nurse (#1) stated she expected staff to wear a gown when flushing a foley catheter and doing a dressing change, and perform hand hygiene after removing gloves and prior to performing other tasks.

PERINEAL CARES

Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 744, stated, ". . . Retracting the foreskin is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32	F 880		

necessary to remove the smegma (thick, cheesy secretion) that collects under the foreskin and facilitates bacterial growth . . . Hold the shaft of the penis . . . securely in one hand. Clean the tip of the penis at the urethral meatus in a circular motion from the center outward and wash down the shaft . . . This follows the principle of cleaning from the least contamination to that of the greatest. . . ."

Observations on 04/07/25 of Resident #6 showed the following:
* 10:15 a.m., a CNA (#6) provided perineal cares for the resident while in bed. The CNA used a washcloth to cleanse the penis shaft and moved up to the penis tip. The CNA (#6) failed to retract the foreskin.
* 2:45 p.m., a CNA (#18) performed perineal cares for the resident while in bed. The CNA (#18) failed to retract the foreskin.
* 3:07 p.m., while performing straight catheterization preparation, a nurse (#19) retracted the foreskin, exposing a large amount of smegma.

During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to follow appropriate infection control practices during male perineal cares.