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 _____	R-C 06/18/2019

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 000}	INITIAL COMMENTS The on-site revisit for the standard Medicare/Medicaid recertification and complaint survey started on 06/17/19 and concluded 06/18/19.	{F 000}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	{F 580}		7/8/19

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

Electronically Signed | 07/02/2019

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{F 580}	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 06/18/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/16/19 CMS-2567 Based on observation, record review, review of facility policy, and staff interview, the facility failed to notify residents' representatives/physician promptly of a change in condition for 1 of 13 sampled residents (Resident #9) reviewed during the on-site revisit. Failure to update residents' representatives/physician on injuries of unknown origin is a violation of residents' rights. Findings include: Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on	{F 580}	Corrective Action: The Director of Nursing or her designee assessed resident #9 to validate that any injuries were reported to the resident, resident responsible party, attending physician, and proper authorities as required. New physician orders were noted, and care plan updated as applicable. Identification of Others: The DPM/designee will conduct a review of residents to validate that any identified injuries have been reported to the resident, resident representative and attending physician and proper authorities as required, new physician orders and care plan updated as applicable.	

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{F 580}	Continued From page 2 05/16/19. This undated policy stated, ". . . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). . . . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . . . discovery of injuries of an unknown source . . . need to alter the resident's medical treatment significantly . . . Unless otherwise noted by the resident, a nurse will notify the resident's representative when: . . . The resident is involved in any accident or incident that results in an injury including injuries of an unknown source . . . there is a significant change in the resident's physical, mental, or psychosocial status . . ." Observation on 06/17/19 at 12:41 p.m. showed Resident #9 had bruising/swelling and a skin tear to her left hand and bruising to her right forearm and shin. During an interview at this time, the certified nursing assistant (CNA) (#1) stated she did not know how the injuries occurred. Review of Resident #9's medical record occurred on June 17-18, 2019. Diagnoses included dementia. The medical record lacked identification of the above injuries and evidence of physician and representative notification.	{F 580}	Systemic Changes: The DON/Designee will provide education to applicable staff on the requirements of reporting injuries to the resident, resident representative, attending physician and proper authorities as required. Further education will include noting any new orders and updating care plan as applicable. Monitoring/QAPI The DON/designee will conduct monitoring through chart review, interviews and observation 3x a week for 3 months to validate that any sustained injury has been reported to the resident, resident representative, attending physician and proper authorities as required. The review will also include validation that new physician orders are noted, and the care plan has been updated. Any identified areas of concern will be promptly corrected. The DON/designee will report any identified trends to the Quality Assurance Committee as needed and monthly until a lessor frequency is deemed appropriate.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		7/8/19

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F 607	Continued From page 3 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement abuse investigation policies regarding injuries of unknown origin for 1 of 13 sampled residents (Resident #9) reviewed during the on-site revisit. Failure to assess, monitor, and investigate injuries of unknown origin placed Resident #9 at risk for abuse/neglect. Findings include: Review of the facility policy titled "Abuse Investigation and Reporting" occurred on 06/18/19. This undated policy stated, ". . . All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. . . ." Review of Resident #9's medical record occurred on June 17-18, 2019. Diagnoses included dementia. The current care plan stated, ". . . At risk for alteration in skin integrity related to: impaired mobility, spending more time in bed,	F 607	Corrective Actions: The Administrator/designee reviewed resident #9 injuries to validate that any injuries of unknown were reported to the resident, resident representative, attending physician and State, Local, and Federal agencies as required. Further corrective actions will include validation that a thorough investigation was conducted, and findings were reported as required. New physician orders will be noted, and care plan updated as applicable. Identification of Others The Administrator/designee will conduct a review of residents to validate that any injuries of unknown origin were reported promptly to the resident, representative, attending physician and State, Local, and Federal agencies as required. Review will also include validation that a thorough investigation was conducted, and findings reported as required. Any new physician orders were noted, and care plans were updated as applicable Any concerns will be promptly corrected.	

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F 607	Continued From page 4 decrease in appetite, wheel self around and often scratch self on walls or on objects in room and bathroom . . . Interventions . . . Observe skin condition with ADL [activities of daily living] care daily; report abnormalities . . ." Current physician's orders included "geri sleeves (long sleeves ok) on in AM [morning] off at HS [bedtime]." A weekly skin assessment, dated 06/15/19, identified no skin issues. Observation on 06/17/19 at 12:41 p.m. showed Resident #9 had bruising/swelling and a skin tear covered with a Band-Aid to her left hand, bruising to her right forearm and shin, and wearing a short-sleeved shirt without geri sleeves in place. The certified nursing assistant (CNA) (#1) stated she did not know how the injuries occurred. Observation on 06/17/19 5:10 p.m. showed Resident #9's left hand covered with a Mepilex dressing and no geri sleeves in place. Review of Resident #9's treatment administration record (TAR) on 06/17/19 at 5:36 p.m. showed staff signed off the geri sleeves for the morning of 06/17/19; however, observations throughout the day on 06/17/19 showed staff failed to apply Resident #9's geri sleeves. A nurse's note, dated 06/17/19 at 11:55 p.m., stated, ". . . area was cleaned and miplex [sic] applied . . ." The record contained no further assessment/description of the bruising/skin tear. During an interview on the afternoon of 06/18/19, a supervisory nurse (#2) agreed direct care staff should report injuries of unknown origin to the nurse.	F 607	Systemic Changes The Administrator/designee will provide education to staff on requirements and process of reporting injuries of unknown origin to the Administrator/designee, resident, resident representative, attending physician and State, Local, and Federal agencies. Further education will include the requirements of completing a thorough investigation including noting physician orders and updating care plan to rule out abuse and the reporting of findings as well. Monitoring The Administrator/designee will conduct audits through record reviews, observation and interviews 3 times a week for 3 months to validate that injuries of unknown origin are promptly reported to the resident, resident representative, attending physician, and State, Local, and Federal agencies as applicable. Auditing will also include validation that a thorough investigation was conducted including noting of new physician orders and the updating of care plans as well as the timely reporting of investigation findings ass applicable. The Administrator/designee will report any identified trends to the quality assurance committee as needed and monthly until a lessor frequency is deemed appropriate.	
{F 657}	Care Plan Timing and Revision	{F 657}		7/8/19

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{F 657} SS=D	Continued From page 5 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JUNE 17-18, 2019, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT FOR RESIDENT #54. Refer to 05/16/19 CMS-2567.	{F 657}	Corrective Action: The DON/designee update resident #54 care plan to reflect current assistance needs as it applies to toileting and current status as it relates to urinary continence. Identification of Others	

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{F 657}	Continued From page 6 Based on record review and staff interview, the facility failed to review/revise the comprehensive care plan to reflect the current status for 1 of 13 sampled resident (Resident #54) reviewed during the on-site revisit. Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for the resident. Findings include: Review of Resident #54's medical record occurred on all days of survey. Diagnoses included chronic kidney disease, muscle weakness, and incontinence. The most recent quarterly Minimum Data Set, dated 04/25/19, identified frequent bladder incontinence, extensive assist of two for toileting, and cognitively intact. Review of Resident #54's care plan stated, ". . . ADL [activities of daily living] Self care deficit . . . hands on staff assist with . . . toileting . . . as needed . . ." The care plan did not address what kind of assistance the resident requires with toileting and if she is continent or incontinent. During an interview on 06/18/19 at 2:10 p.m., a licensed practical nurse (LPN) (#4) stated Resident #54 is a check and change only and staff do not take her to the bathroom. The care plan failed to accurately reflect Resident #54's current level of assistance required with toileting.	{F 657}	The DON/Designee will conduct a review of residents to validate that assistance needs related to toileting and continence status are care planned. Corrective actions will be implemented if concerns are identified. Systemic Changes The DON/designee will provide education to the inter-disciplinary team on the requirements to address the update timely the toileting assistance needs and continence status on the residents' care plan as needed. Monitoring The DON/designee will conduct reviewd 3x a week for 3 months to validate that residents' care plans include timely updates of toileting assistance needs and continence status. Any concerns will be corrected. The DON/ designee will report any identified trends to the Quality Assurance Committee as needed and monthly until a lessor frequency is deemed appropriate.	
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	{F 658}		7/8/19

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{F 658}	Continued From page 7 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JUNE 17-18, 2019, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/16/19 CMS-2567. Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice for 1 of 13 sampled residents (Resident #1) during administration of insulin. Failure to ensure staff offered food within 15 minutes of the administration of a rapid-acting insulin may result in hypoglycemia (low blood sugar). Findings include: Patient package insert information for Humalog insulin, found at www.lillymedical.com. and dated 2017, stated, ". . . Products containing Humalog differ from regular human insulin because of their rapid onset of action as well as a shorter duration of activity. When used as a meal-time insulin, the dose of Humalog should be given within 15 minutes before or immediately after the meal. . . ." Review of Resident #1's medical record occurred June 17-18, 2019. Current physician's orders included an order, dated 06/12/19, that stated, "Regular diet Dysphagia Mechanical Soft texture, Regular consistency . . . Enteral Feed Order at	{F 658}	Corrective Actions The DON/designee assessed Resident #1 to validate no negative outcomes occurred related to timing of rapid onset insulin administration and food intake. Any concerns identified were reported to the resident, resident representative, attending physician, new physician orders noted and care plan update if applicable. Identification of Others The DON/designee will review residents who receive rapid onset insulin to validate that administration of insulin meets requirement of food intake timeliness. Resident, resident representative, attending physician will be notified, new physician orders noted , and care plan update as applicable. Systemic changes The DON/designee will provide education to applicable nursing staff on the requirements of validating administration of rapid onset insulin and timely food intake requirements to prevent fluctuations in blood glucose levels. Monitoring/QAPI The DON/designee will conduct monitoring 3x a week for 3 months through interviews and observation of	

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{F 658}	Continued From page 8 bedtime . . ." The medication administration record included an order, dated 06/12/19, that stated, ". . . Insulin Lispro Solution [Humalog] Inject 3 unit subcutaneously [below the skin] before meals and at bedtime for DM [diabetes mellitus] Hold if tube feeding is held . . ." Observation on 06/17/19 showed the following: * 12:05 p.m. showed a staff nurse (#3) administered three units of Humalog to Resident #1 during a therapy session. The staff nurse (#3) did not ensure to provide a meal 15 minutes following administration of the Humalog. * 12:55 p.m. showed Resident #1 continued to work with therapy. She reported staff offered water but no other food or drink. * 1:25 p.m. showed Resident #1 returned to her room from therapy due to nausea and vomiting. Staff nurse (#3) offered ginger ale and crackers at this time (1 hour and 20 minutes after administration of Humalog). Staff failed to assess the resident for hypoglycemia, check the resident's blood sugar, and encourage and educate the resident on the importance of eating with the administration of Humalog. The record did not show a blood sugar recorded until 5:00 p.m. with a result of 99 milligrams/deciliter. During an interview with an administrative nurse (#2) on 06/18/19 at 3:45 p.m., the nurse reported she expected food to be offered within 20 minutes of administration of a rapid-acting insulin like Humalog.	{F 658}	administration of rapid onset insulin to validate timely food intake to prevent fluctuations in blood glucose levels. Any concerns will be promptly corrected. The DON/designee will report any identified trends to the Quality Assurance Committee as needed and monthly until a lessor frequency is deemed appropriate.	
{F 690} SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	{F 690}		7/8/19

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{F 690}	Continued From page 9 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JUNE 17-18, 2019, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT.	{F 690}	Corrective Actions The DON/designee assessed resident #54 to validate that resident was assessed for change in condition. UA was	

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{F 690}	Continued From page 10 Refer to 05/16/19 CMS-2567. Based on record review, and staff interview, the facility failed to provide timely services and treatment for 1 of 13 sampled resident (Resident #54) with signs and symptoms of a urinary tract infection (UTI). Failure to ensure prompt diagnosis and treatment of a UTI may result in unnecessary discomfort, pain, behaviors, and/or sepsis. Findings include: Review of Resident #54's medical record occurred on all days of survey. Diagnoses included chronic kidney disease (severe), and mixed incontinence. The most recent quarterly Minimum Data Set, dated 04/25/19, identified frequently incontinent of bladder, extensive assist of two for toileting, and to be cognitively intact. Change In Condition - DAILY INTERDISCIPLINARY REPORT identified the following: * 06/13/19 ". . . Increased confusion, question UTI . . ." * 06/14/19 ". . . Confused, strong urine, question UTI . . ." * 06/16/19 ". . . Very confused, called 6 times on PM's (evening shift), question UTI, URI [upper respiratory infection], O2 [oxygen]sat [saturation]-question med change. . . ." Nurses' notes identified the following: * 06/17/19 at 3:25 a.m.: ". . . Resident had a very rough night. . . . increasingly confused. . . ." * 06/18/19 at 12:25 a.m.: ". . . Resident remains confused . . . she know [sic] she is talking goofy .	{F 690}	ordered and negative. Resident, resident representative and MD notified and care plan updated as applicable. Identification of others The DON/designee will conduct a 7 day look back to validate that residents experiencing signs and symptoms of a UTI have had appropriate timely follow up including physician notification, new physician orders noted. This review will also include the validation that resident, resident representative notification and that the care plan has been revised as applicable. Systemic Changes The DON/designee will provide education to license nurses on the requirements of timely physician notification of signs and symptoms of a UTI, and request for treatment related to assessment findings. Education will include timely notification of resident, resident representative, and revision of the care plan if applicable. Monitoring/QAPI The DON/ designee will conduct monitoring 3x a week for 3 months to validate that physicians are notified timely of signs and symptoms of a UTI and physician orders for treatment are promptly noted. Monitoring will also include validating that resident, resident ,representative has been notified and care plan has been revised if applicable.	

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 _____	R-C 06/18/2019

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 690}	Continued From page 11 . ." During an interview on 06/18/19 at 2:20 p.m., an administrative nurse (#2) verified Resident #54's increased confusion and symptoms of UTI and stated she expected staff to would have completed an SBAR [communication with medical provider] prior to 6 days following the first symptom.	{F 690}	The DON/designee will report any identified trends to the Quality Assurance Committee as needed and monthly until a lessor frequency is deemed appropriate.	