STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR , FARGO, North Dakota, 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
F0000	INITIAL COMMENTS an unannounced onsite investigation survey regarding a complaint and a facility reported incident was completed on December 30, 2025. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F0000		01/07/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F0655	CMS-2567 Plan of Correction Facility Name: The Meadows on University Address: 1315 S University Dr, Fargo, ND 58103 Provider Number: 355024 Survey Date: 12/29/2025-12/30/2025 POC Submission Date: January 22, 2026 Corrective Actions Resident #1s care plan was immediately reviewed by DON and updated on 12/29/2025 to accurately reflect all assessed ADL assistive needs, including required level of assistance and use of adaptive equipment as appropriate. The DOR responsible for the incomplete care plans were re-educated by the DON on 1/16/2026 on CMS F655 requirements, including timely development of individualized care plans within 48 hours of admission and alignment with completed assessments. The IDT team will be educated on baseline careplans requirements on 1/16/2026 by the DON. DON educated by regional resource on 1/14/2026 on CMS F655 requirements. Identification of others On 01/02/2026, the Director of Nursing (DON) completed a facility-wide audit of all current residents' care	01/16/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0655 SS = D	Continued from page 1 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a baseline care plan to reflect the needs for 1 of 1 sampled resident (Resident #1) identified as a new admission. Failure to develop and implement a baseline care plan may result in inconsistent and unsafe care for all newly admitted residents. Findings include: Review of the facility policy titled "Baseline Care Plan" occurred on 12/30/25. This policy, dated 05/05/25, stated, ". . . The baseline care plan will . . . be developed within 48 hours of a resident's admission. . . . Include the minimum healthcare information necessary to properly care for a resident . . ." Review of Resident #1's medical record occurred on all days of survey and identified an admission date of 12/10/25. The comprehensive assessment, dated 12/12/25, stated, ". . . Transfer – assist x1 (assist of one) . . . Eating – independently . . . Toileting – assist x1 . . ." The resident's base line care plan, dated 12/10/25, identified no interventions for specific needs such as	F0655	Continued from page 1 plans to identify any additional residents with incomplete or missing care plan interventions related to ADL assistive needs within the required 48-hour timeframe. Four other residents were identified with incomplete 48-hour care plans related to ADLs. These were updated and charts were reviewed to ensure no negative impact to identified residents. Systemic Changes All admissions will be reviewed in daily IDT meetings to ensure baseline careplans are completed within 48 hours of admission. Monitoring DON or designee will audit all new admission care plans twice weekly for four (4) weeks to ensure completion within 48 hours and inclusion of all identified ADL assistive needs then audits will then be conducted once weekly for four weeks and then monthly until reviewed through QAPI. Date of compliance 1/16/2026 Administrator/DON Attestation I attest that the corrective actions described will be implemented and sustained, and that residents will not be adversely affected while these corrections are in process. Administrator/DON Name: Spencer Jones Title: Administrator Signature: Date: 1/22/2026	

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F0655 SS = D	Continued from page 2 transfers, eating, and toilet use. During an interview on 12/31/25 at 10:35 a.m., an administrative staff member (#1) confirmed staff failed to develop a baseline care plan for Resident #1.	F0655		