

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER The Meadows on University		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 S University Dr Fargo, ND 58103	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39685</p> <p>1. Based on observation, record review, review of manufacturer's instructions for use, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 1 resident (Resident #1) who required rapid-acting insulin. Failure to administer rapid acting insulin within the time frame specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction.</p> <p>Findings include:</p> <p>Review of prescribing information for Humalog insulin (a rapid-acting insulin), found at https://www.humalog.com, occurred on 01/13/25, and stated, Administer HUMALOG . within 15 minutes before a meal or immediately after a meal.</p> <p>Review of Resident #1's medical record occurred on 01/13/25. Physician's orders included Humalog insulin 10 units three times a day. The Minimum Data Set (MDS), dated [DATE], identified dependent on staff for eating,</p> <p>Observations on 01/13/25 showed a nurse (#2) checked Resident #1's blood sugar at 11:57 a.m., obtained a blood glucose reading of 107 milligrams/deciliter (mg/dl), and administered 10 units of Humalog. At 12:56 p. m. (53 minutes after receiving a rapid acting insulin), Resident #1 received the noon meal, and staff assisted with eating.</p> <p>During an interview on 01/13/25 at 5:26 p.m., an administrative nurse (#1) stated she expected staff to serve a meal within 15 minutes of administering a rapid-acting insulin.</p> <p>2. Based on record review, professional reference, and staff interview, the facility failed to obtain routine, regularly scheduled medication for 1 of 1 closed record reviewed (Resident #8). Failure to ensure Resident #8 received routine, regularly scheduled medications may result in exacerbation of congestive heart failure (CHF) and other adverse effects.</p> <p>Findings include:</p> <p>Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 63, stated, . medications ordered by the physician or primary care provider . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #8's medical record occurred on 01/13/25 and included the diagnosis of CHF. Medications included Lasix (a diuretic) 40 milligrams (mg) in the morning for CHF.</p> <p>Nursing progress notes included the following:</p> <p>* 5/17/24 at 11:41 a.m. Lasix . Give 40 mg . for CHF Medication not available .</p> <p>* 5/18/24 at 10:36 a.m. Lasix received and resumed as ordered .</p> <p>During an interview on 01/13/25 at 5:48 p.m., an administrative nurse (#1) verified Resident #8 did not receive his scheduled Lasix on 05/17/24.</p> <p>40489</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>40489</p> <p>Based on record review, review of a professional reference, and resident and staff interviews, the facility failed to provide appropriate toileting for 1 of 1 confidential resident (Resident A) who required staff assistance with toileting/check and change. Failure to provide toileting/check and change may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries.</p> <p>Findings include:</p> <p>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 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 . Habit training, also referred to as timed or prompted voiding and scheduled toileting, 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 .</p> <p>Review of Resident A's medical record occurred on 01/13/25. The careplan stated, . I have physical functioning deficit related to limited mobility . Toilet Use-Check and change assist .</p> <p>During an interview on 01/13/25 at 5:36 p.m., Resident A stated, he/she does not get their incontinent product changed for long periods of time.</p> <p>Review of Resident #A's check and change record, dated December 15th, 2024 through January 12, 2025, (29 days) identified the following:</p> <ul style="list-style-type: none"> * Four days, not checked and changed for 24 hours. * Six days, checked and changed one time in 24 hours. * Fifteen days, checked and changed two times in 24 hours. * Four days, checked and changed three times in 24 hours. <p>During an interview on 01/13/25 at 5:26 p.m., an administrative staff member (#1) stated she expected staff to assist residents with toileting/check and change every 2-3 hours and per resident request.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>39685</p> <p>40489</p> <p>Based on observation, review of facility policy, and resident interviews, the facility failed to serve foods at palatable temperatures for 2 of 2 sampled residents (Resident #1 and #3) who received a meal tray in their room. Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition.</p> <p>Findings include:</p> <p>Review of the facility policy titled Food Preparation and Service occurred on 01/13/25. This policy, dated November 2022, stated, . Ready to eat foods that require reheating . cooked to at least 135 degrees F [Fahrenheit] for holding for hot service.</p> <p>- Observation on 01/13/25 at 12:45 p.m., showed the CNA (#3) delivered the noon meal to Resident #1. The certified nurses aide (CNA) gave the resident a bite of the fish, the resident spit it out, refused to eat the rest of the food, and stated, The food is cold, I would like warm food. The CNA (#3) removed the tray from the room and returned with a new tray. Resident #1 stated he often receives cold food and asks for a warm food tray.</p> <p>- Observation on 1/13/25 at 1:07 p.m. showed a nurse (#5) removed a meal tray from the conveyor cart in the hallway and entered Resident #3's room. The nurse told the resident she would change the catheter bag first. At 1:19 p.m., the nurse (#5) removed the cover from the resident's plate. At 1:20 p.m., this surveyor checked the temperature of the fish stick and obtained a reading of 120.5 degrees Fahrenheit. The resident then took a bite of the fish stick and stated, That is barely warm, not hot by any means.</p> <p>During an interview on 1/13/25 at 5:36 p.m., a confidential resident (Resident A), stated, I often get food served cold to me and I have to ask them to reheat it.</p> <p>Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46477</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 1 supplemental resident (Resident #7) who tested positive for influenza and 1 of 6 sampled residents (Resident #3) observed during cares. Failure to practice infection control standards related to influenza precautions and hand hygiene has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Isolation - Categories of Transmission-Based Precautions occurred on 01/13/25. This policy, revised September 2022, stated, . Droplet Precautions . Masks are worn when entering.</p> <p>Review of the facility's policy titled Handwashing/Hand Hygiene occurred on 01/13/25. This policy, dated August 2019, stated, . Use an alcohol-based hand rub . or . soap . and water for the following situations . Before and after . handling food .Before and after assisting a resident with meals .</p> <p>- Review of Resident #3's medical record occurred on 01/13/25 and identified a foley catheter.</p> <p>Observation on 01/13/25 at 1:19 p.m. showed a nurse (#5) donned a gown and gloves to change Resident #3's catheter bag. The nurse was unable to disconnect the catheter bag and stated she would need to go get some assistance, but I will set your lunch tray up first. The nurse then removed her gown and gloves and without performing hand hygiene, removed the cover from Resident #3's meal tray, opened and placed the tartar sauce on the plate, opened the milk carton and poured the milk into a glass, and opened the pudding container. The nurse (#5) failed to perform hand hygiene after touching the resident's catheter and glove removal and before assiting with the meal.</p> <p>- Review of Resident #7's medical record occurred on 01/13/25. The current physician's orders identified contact and droplet precautions related to influenza.</p> <p>Observation on 01/13/25 at 12:55 p.m. showed a staff member (#4) entered Resident #7's room without masking to deliver laundry.</p> <p>During an interview on 01/13/25 at 5:24 p.m., an administrative staff member (#1) stated she expected staff to follow recommended infection control practices.</p> <p>40489</p>		