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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows on University	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 1 sampled resident (Resident #1) on contact precautions. Failure to practice infection control standards related to contact precautions and hand hygiene for staff and residents has the potential to spread infection throughout the facility.Findings include:Review of the facility policy titled Management of C. [Clostridioides] Difficile Infection [a contagious bacterial infection] occurred on 12/04/25. This policy, revised 04/10/25, stated, . All staff are to wear gloves and a gown upon entry into the resident's room and while providing care . Hand hygiene shall be performed by handwashing with soap and water . Encourage/assist residents to wash hands frequently.Review of the facility policy titled Hand Hygiene occurred on 12/04/25. This policy, revised 04/10/25, stated, . If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. For conditions involving a resident, or the resident's environment, who is isolated for Clostridioides difficile [C. diff]. hand washing with soap and water is required.Review of Resident #1's medical record occurred on 12/04/25 and included a diagnosis of enterocolitis due to clostridium difficile. The current care plan stated, [Resident #1] has potential for complications r/t [related to] C-Difficile . isolation as ordered by physician or following CDC [Centers for Disease Control and Prevention] guidelines . [Resident #1] is on contact/enteric precautions r/t C. diff. Ensure strict adherence to hand hygiene protocols before and after patient contact . Use appropriate PPE [personal protective equipment] . as per isolation guidelines.Observation on 12/04/25 at 9:22 a.m. showed a CNA (#2) enter Resident #1‘s room, applied gloves and without applying a gown, pivot transferred the resident from bed. Using a walker, Resident #1 ambulated to the bathroom and the CNA assisted her onto the toilet. Resident #1 independently completed toileting cares. The CNA transferred the resident off the toilet, and without performing hand hygiene, the CNA (#2) and resident exited the bathroom. The CNA assisted the resident to a wheelchair and the table in the room, placed a meal tray on the table, removed the soiled gloves, used hand sanitizer, and exited Resident #1‘s room. The CNA (#2) failed to apply a gown. wash hands with soap and water and encourage Resident #1 to perform hand hygiene.During an interview on 12/04/25 at 3:35 p.m., an administrative nurse (#1) stated she expected staff to follow contact-based precautions and perform hand hygiene as specified in facility policies.

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