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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows on University	1315 S University Dr Fargo, ND 58103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of Medicare Part A letters/notices, review of facility policy, and staff interview, the facility failed to ensure the resident and/or their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for 2 of 3 residents (Resident #43 and #81) reviewed for termination of Medicare Part A services. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights regarding Medicare Part A services.Findings include:Review of facility policy titled Advance Beneficiary Notices occurred on 06/10/26. This policy, dated 06/25/25, stated, . The facility shall inform Medicare beneficiaries of his or her potential liability for payment. the form shall comply with related instructions and regulations regarding the use of the form. The notice shall . obtain beneficiary or representative signature.- Review of Medicare Part A beneficiary notices identified Resident #43 discharged from Medicare Part A on 05/20/26. The SNFABN failed to identify if the resident/resident's representative chose to continue services, discontinue services, or request a demand bill.- Review of Medicare Part A beneficiary notices identified Resident #81 discharged from Medicare Part A on 01/23/26. The SNFABN failed to identify the estimated cost of services, if the resident/resident's representative chose to continue services, discontinue services, or request a demand bill and lacked a signature from the beneficiary or the representative.During an interview on 06/09/26 at 2:22 p.m., an administrative nurse (#1) confirmed the SNFABN's for Residents #43 and #81 were incomplete.

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and resident and staff interviews, the facility failed to provide housekeeping services to maintain a safe, clean, comfortable and homelike environment for 4 of 4 days of survey. Failure to ensure the resident environment and equipment are kept clean and sanitary does not promote a homelike living environment or enhance the residents' quality of life. Findings include: Review of the facility policy titled Safe and Homelike Environment occurred on 06/10/26. This policy, dated May 2025, stated, . In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. - Observation on all days of survey showed large amounts of food debris on Resident #3's wheelchair and stains on the padded footrests. During an interview on 06/10/26 at 1:40 p.m. an administrative staff member (#1) stated she expected staff to clean wheelchairs, including footrests. Observations on 06/07/26 showed the following; * At 11:12 a.m., a water trail from the central hallway bathing room down the entire length of the hallway and around to the next hallway. In addition, two alcohol wipe wrappers, food debris, a single piece of paper and straw wrappers on the floor outside of room [ROOM NUMBER]. * At 11:30 a.m., an empty chip bag on a side table, a straw on the floor, and a used blanket on a couch in the common area adjacent to the Dakota Dining Room. * At 12:17 p.m., a sticky substance on the floor and on the countertop in Resident D's room and the room appeared disorganized and cluttered. * At 12:00 p.m., multiple areas of crumbs, a foil candy wrapper, and debris on the hallway floor by room [ROOM NUMBER] and a large area of dried brown substance splattered on the floor near the central supply room door. * At 2:05 p.m., a candy wrapper and multiple areas of crumbs along the hallway floor outside rooms [ROOM NUMBERS]. Observations on 06/09/26 showed the following; * At 10:41 a.m., the grates of a black pedestal fan coated with dust and clumps of dust blowing toward Resident #45's bed. When asked if staff clean the fan, the resident stated, No. * At 11:57 a.m., the grates and blades of a white table fan coated with dust located on a bedside table in Resident #17's room. During an interview on 06/09/26 at 2:00 p.m., administrative nurse (#1) stated he/she expected the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	housekeeping staff to clean the fans when needed. During an interview on 06/09/26 at 3:20 p.m., the maintenance supervisor (#9) stated all staff are expected to monitor their work areas and ensure environmental concerns are promptly addressed to maintain a clean and sanitary environment. - Observation on 06/10/26 at 10:55 a.m. showed large amounts of scrambled eggs, toast, and other food particles under two tables in the main dining room. The noon meal is scheduled from 11:00 a.m. to 1:00 p.m. and the dietary staff had started serving the noon meal.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and resident and staff interviews, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 18 sampled residents (Resident #1 and #30). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Comprehensive Care Plans occurred on 06/10/26. This policy, dated May 2025, stated, . The comprehensive care plan will be reviewed and revised by the interdisciplinary team . - Review of Resident #1's medical records occurred on all days of survey. A progress note dated 5/26/26, stated, . The resident informed this writer that, moving forward, he only wishes to see his sister in open areas of the building. and the resident has expressed that no further information is to be shared with her.Resident #1's care plan failed to include choices related to his sister's involvement with his care. - Review of Resident #30's medical record occurred on all days of survey. The care plan stated, . has potential for complications/injury r/t [related to] smokes cigarettes. During an interview on 06/08/26, at 11:15 a.m., an administrative nurse (#1) confirmed Resident #30 is not a smoker. During an interview on 06/09/26, at 3:40 p.m., Resident #30 stated he/she does not smoke. The staff failed to review and revise Resident #30's care plan to reflect his/her current smoking status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, review of facility policy, and resident and staff interviews, the facility failed to provide the necessary services for 4 of 18 sampled residents (Resident #1, #10, #30, and #55) who required assistance with bathing. Failure to provide bathing as scheduled may result in poor personal hygiene and decreased self-esteem. Findings include: Review of facility policy titled Activities of Daily Living occurred on 06/10/26. This policy, dated May 2025, stated, . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, has impaired physical functioning r/t [related to] fatigue and weakness . Shower/bathe . A [assist] [of] 1 . During an interview on 06/08/26 at 4:20 p.m., Resident #1 stated he/she requested two showers a week, but usually only receives one a week. Review of Resident #1's bathing/shower record identified showers scheduled twice weekly on Wednesdays and Sundays. The bathing record, dated May 13 - June 7, 2026, showed the resident received a shower on four of nine scheduled bath days, refused once, and not applicable twice. The record failed to show whether staff offered an alternate time or day for the refused baths and explain not applicable. - Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, . has impaired physical functioning . Shower/Bathing: A x 1 . Review of Resident #10's bathing record identified bathing scheduled twice weekly on Monday and Saturday. The bathing record, dated May 12 - June 8, 2026, showed the resident received a bath on two of eight scheduled bath days and refused six times. The record failed to show whether staff offered an alternate time or day for the refused baths. - Review of Resident #30's medical record occurred on all days of survey and identified a hospitalization from May 21-29, 2026. The current care plan stated, . has impaired physical functioning . Shower/Bathing: A x 1 . Resident #30's medical record identified bathing scheduled twice a week on Wednesday and Sunday. The record lacked documentation of a bath/shower or refusal on three of three scheduled bath days. Review of Resident #55's medical record occurred on all days of survey. The current care plan stated, . has impaired physical functioning . Personal Hygiene: A [assist] x 1 . has ADL [activities of daily living] Self-care deficit as evidence by . paraplegia, muscle weakness . Review of The Resident #55's bathing record identified bathing scheduled twice a week on Thursday and Sundays. Review of the bathing record, dated April 12 to May 31, 2026, showed the resident received baths on eight of 15 scheduled bath days. The record lacked documentation for seven of the scheduled bath days. During an interview on 06/10/26 at 1:10 p.m., an administrative staff member (#1) stated she expected residents bathed according to their schedule and if they refuse, to notify the nurse and document in the resident's record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, record review, review of facility policy, and staff interview, the facility failed to provide care and services for 1 of 1 supplemental resident (Resident #57) observed with a wound dressing. Failure to follow physician's orders regarding dressing changes may result in delayed treatment, infection, and increased wound complications. Findings include:Review of the facility policy titled Clean Dressing Change occurred on 06/10/26. This policy, dated May 2025, stated, . It is the policy of this facility to provide wound care in a manner to decrease potential for infection . Physician's orders will specify type of dressing change and frequency of changes. Assure dressing is labeled with initials and date.Review of Resident #57's medical record occurred on June 7, 9 and 10, 2026. A physician's order dated 06/02/26 stated, Skin tear to right lower extremity. Cleanse area, pat dry, keep steri strips intact. Cover with 4x4 gauze and secure with tape QD [every day] and prn [as needed].Observation on 06/07/26 at 4:30 p.m. showed an occlusive dressing to Resident #57's right lower calf dated 06/03/26 . Observation on 06/09/26 at 5:00 p.m. showed an undated, uninitialed white dressing (not gauze) to Resident #57's right lower calf. Observation on 06/10/26 at 10:50 a.m. showed an undated and uninitialed occulsive dressing to Resident #57's right lower calf. Review of Resident #57's treatment administration record from 06/02/26 through 06/10/26 lacked documentation facility staff changed the resident's dressing on June 2, 3, and 5, 2026 (3 of the 9 days). During an interview on 06/10/26 at 1:40 p.m. an administrative staff member (#1) stated she expected staff to follow physician orders for the type of wound dressing and the frequency of changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interview, the facility failed to provide adequate housekeeping services to prevent accidents on 1 of 4 days of survey (06/07/26). Failure to clean standing water from the floor placed residents, staff, and visitors at risk of falls and injury.Findings include: -Observation on 06/07/26 at 11:05 a.m. showed a trail of water on the floor extending down the central hallway. Observation of staff and residents walking in hallway. The water remained on the floor until 11:48 a.m. (43 minutes). -Observation on 06/07/26 at 11:30 a.m. showed water dripped from the ceiling air-conditioning unit into a bucket near the Dakota Dining Room. Observation showed a puddle of water surrounding the bucket and extended under and into the doorway threshold of the Dakota Dining Room. Staff propped a wet floor sign against the wall. Observation of staff and residents walking in hallway. The water remained on the floor until 1:10 p.m. (One hour and 40 minutes) -Observation on 06/07/26 at 2:28 p.m. showed water continued to drip into a bucket from the ceiling air-conditioning unit near the Dakota Dining Room. Facility staff placed a yellow caution sign over the puddle of water on the floor. At 3:05 p.m., observation revealed the puddle of water had increased in size and extended over a larger area of the floor than previously observed. During an interview on 06/09/26 at 3:20 p.m., the maintenance supervisor (#9) stated all staff are expected to monitor for water on the floor and other potential safety hazards and to clean them up promptly to prevent accidents and maintain a safe environment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of resident council meeting minutes, review of facility policy, confidential resident, family, and staff interviews, the facility failed to ensure sufficient nursing staff and related services are available to meet the residents' need for 4 of 18 sampled residents (Resident E, J, N, and P), and 12 supplemental residents (Resident A, B, C, D, F, G, H, I, K, L, M, and O) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights, physical, mental, and psychosocial well-being, and/or provide a safe environment for all residents. Findings Include: Review of facility policy titled Call lights: Accessibility and Timely Response occurred on 06/10/26. This policy, dated 06/15/25, stated, . All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate person should be notified. Review of resident council meeting minutes dated 12/15/25, 02/23/26, 03/20/26, and 04/17/26, identified residents reported long call light response times, unanswered call lights after 6:00 p.m., staff turning off call lights, and staff failing to return after acknowledging resident requests. Confidential interviews conducted June 7-8, 2026 identified the following: * 06/07/26 in the afternoon Resident E stated it can take an hour for someone to answer my call light. * 06/07/26 at 11:29 a.m. Resident F stated at times she waits one hour for her call light to be answered. During an interview on 06/07/26 at 11:38 a.m., a certified nurse aide (CNA) (#12) stated there were currently six CNAs working the day shift and reported seven CNAs were scheduled; however, one had called in sick. During an interview on 06/07/26 at 11:41 a.m., a nurse (#7) stated, I am the only nurse in the building, but there's another nurse coming at noon. When asked if it was normal staffing for one nurse in the building until noon, the nurse stated, There's supposed to be three nurses in the building, I am the only nurse for long term care and there is another nurse on South rehab. The nurse (#7) stated there are two nurses scheduled for long term care. * 06/07/26 at 11:55 a.m. Resident A stated the average call light wait time is 30 to 45 minutes, usually in the evenings. * 06/07/26 at 12:00 p.m. Resident G stated, between 6:00 p.m. and 7:30 p.m., it often takes one to two hours for staff to answer the call light. * 06/07/26 at 12:04 p.m. Resident H stated it occasionally takes one and a half hours for staff to answer the call light. especially between 2:00 p.m. and 3:00 p.m.* 06/07/26 at 12:15 p.m. Resident D stated the call light wait times can be anywhere from an hour to two hours usually late in the evenings and on weekends. * 06/07/26 at 12:20 p.m. Resident I stated it takes an average of one and a half hours for staff to answer the call light at times. * 06/07/26 at 12:34 p.m. Resident K stated call lights are ridiculous, and it takes staff 45 minutes to one hour to answer the call light just to get water and stated last week he/she put the call light on for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	another resident and the call light was not answered until one hour and 35 minutes later. *06/07/26 at 2:31 p.m. Resident L stated it often takes 45 minutes to one hour for staff to answer the call light and stated two nights ago there were only three CNAs and two nurses for the whole building. * 06/07/26 at 2:42 p.m. Resident P stated the average call light wait time is 15 to 30 minutes. * 06/07/26 at 3:00 p.m. Resident B stated the average call light wait time is 30 to 45 minutes, mainly on the weekends and evenings. * 06/07/26 at 3:47 p.m. Resident C stated call light wait times can range 30 minutes to one hour. * 06/08/26 at 8:00 a.m. Resident J stated my call light last night was on from 9:30 p.m. to midnight. I really struggled; I could not get anyone in to help me. * 06/08/26 at 9:06 a.m. Resident O stated the staff say they are short staffed and it often takes 45 minutes for staff to answer the call light.* 06/08/26 at 9:45 a.m. a family member AA stated it can take up to 35 minutes for staff to answer the call light and assist the resident.* 06/08/26 at 4:20 p.m. Resident N stated most of the time and it takes them 45 to 60 minutes to answer the call light. * 06/08/26 at 4:30 p.m. Resident M stated call light wait times are sometimes 30 to 45 minutes. During an interview on 06/10/26 at 1:40 p.m., an administrative nurse (#1) stated he/she expected staff to answer call lights as soon as possible and no longer that 15 minutes.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of resident census on 3 of 4 days of survey (June 7, 2026 - June 9, 2026). Failure to post the resident census may impede the facility's ability to evaluate staffing levels in relation to the number of residents residing in the facility.Findings include:Review of the facility policy titled Nurse Staffing Posting Information occurred on 06/10/26. This policy, dated 05/16/26, stated, . The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: . Facilities current resident census .- Observation on June 7-9, 2026, identified the facility failed to include the resident census number on the nurse staffing information.During an interview on 06/09/26 at 3:30 p.m., an administrative staff member (#1) stated she expected the human resource staff to complete and post a daily census/staffing report.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, review of facility policy, and review of manufacturer's instructions, the facility failed to ensure a medication error rate of less than five percent for 2 of 25 medications observed during medication administration. Two medication errors occurred during staff administration of 25 medications, which resulted in an eight percent error rate. Failure to follow facility policy and pharmacy instructions may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include:Review of facility policy titled Insulin Pen occurred on 06/10/26. This policy, dated 06/05/25, states, . Prime the insulin pen . With the needle pointing up, push the plunger, watch to see that at least one drop of insulin appears on the tip of the needle.Review of manufacturer instructions for Advair Diskus (dry powder inhaler), occurred on 06/10/26. These instructions, revised March 2026, states, . ADVAIR DISKUS can cause serious side effects, including . fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using ADVAIR DISKUS to help reduce your chance of getting thrush.- Observation on 06/07/26 at 4:34 p.m., a nurse (#7) prepared an insulin pen. The nurse dialed 2 units of insulin, then held the insulin pen horizontally (needle to the side). The nurse failed to prime the insulin pen pointing upward.- Observation on 06/09/26 at 8:24 a.m., a Medication Aide (MA) (#6) administered Fluticasone-Salmeterol Inhalation Aerosol (Advair) to a resident. Review of the pharmacy label stated, . Rinse mouth after each use. The MA failed to instruct the resident to rinse their mouth after administering each inhaler.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy, and staff interview, the facility failed to ensure food items were stored and monitored in a safe manner in 1 of 1 kitchen and 1 of 1 kitchenette observed. Failure to properly store, label, date, monitor, and discard food items may result in the consumption of unsafe food and place residents at risk for foodborne illness.Findings include:Review of facility policy titled, Monitoring of Cooler/Freezer Temperatures occurred on 06/10/26. This policy, dated 06/05/25, stated, . Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date . discarded . Review of facility policy titled, Foods Brought by Family/Visitors occurred on 06/10/26. This undated policy stated, . Food brought . will be labeled and stored in a manner that is clearly distinguishable . Containers will be labeled with the resident's name, the item and the ?use by' date. The food service staff will discard perishable foods on or before the ?use by' or three (3) days from opening date. will discard any foods . show obvious signs of potential foodborne danger (. mold growth .).Observation on 06/07/26 at 11:10 a.m., showed a container of green beans dated 05/05/26 located in the walk-in refrigerator. On 06/08/26 at 10:00 a.m. showed a bottle of V8 juice undated, unlabeled, and exhibited visible mold growth inside the bottle, and an unlabeled and undated Subway sandwich located in the kitchenette at the south nursing station.The facility failed to maintain sanitary food storage practices and ensure food items were properly dated, labeled, monitored, and discarded when no longer safe for consumption.During an interview on 06/08/26 at 10:20 a.m., the dietary manager (#3) confirmed staff should monitor refrigerators to ensure expired, unlabeled, and unidentified food items are discarded.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Some	Provide and implement an infection prevention and control program. Based on observation, review of facility policies, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 7 sampled residents (Resident #2 and #7) observed during cares, 1 of 5 residents observed during medication pass (Resident #19), and one laundry room. Failure to follow infection control standards related to hand hygiene, glove use, medication administration, the use of personal protective equipment (PPE) and enhanced barrier precautions (EBP), and storage of soiled/clean items within the laundry room has the potential to spread infection throughout the facility. Findings Include: Review of the facility policy titled Enhanced Barrier Precautions occurred on 06/09/26. This policy, dated 04/11/25, stated, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (. indwelling catheters, feeding tubes .) . Make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . Transferring . changing briefs or assisting with toileting . Review of facility policy titled Hand Hygiene occurred on 06/10/26. This policy, dated 04/10/25, stated, . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of facility policy titled Laundry occurred on 06/10/26. This policy, dated 06/05/25, stated, . laundry area will provide. PPE. Soiled laundry shall be kept separate from clean laundry at all times. -Observation on 06/07/26 at 4:46 p.m. showed Resident #2's door with an EBP sign. A certified nurse aide (CNA) (#2) entered the room, applied gloves, and completed perineal cares. The CNA removed the soiled gloves, and without performing hand hygiene, applied new gloves, assisted the resident to a sitting position and transferred the resident with a stand lift. The CNA (#2) failed to apply a gown prior to completing perineal cares and failed to perform hand hygiene after removing the soiled gloves. -Observation on 06/08/26 at 9:15 a.m. showed a nurse (#10) assisted Resident #7 with toileting and performed perineal care. Without removing the soiled gloves, the nurse reached into her pocket and used the walkie talkie to call for assistance. The nurse removed the soiled gloves and without performing hand hygiene, moved the resident's wheelchair and removed the resident's pants and shoes. The nurse performed hand hygiene and left the room as CNA (#11) completed perineal care and assisted the resident into the wheelchair. The CNA (#11) removed the soiled gloves and without performing hand hygiene, assisted the resident to the sink. The staff failed to remove gloves and complete hand hygiene before performing other tasks. During an interview on 06/10/2026 at 1:20 p.m., an administrative nurse (#1) stated she expected staff to wear a gown and gloves when completing high contact care for residents in EBP and perform hand hygiene after removing gloves. -Observation on 06/08/26 at 7:45 a.m. showed the following in the laundry room: *The soiled laundry area contained gloves, but no additional PPE supplies. Lift slings and (continued on next page)

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	06/10/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioning devices stored on top of the washing machine. *The clean laundry area contained a covered container of soiled kitchen towels. The facility failed to ensure separation of clean and soiled items, protect resident care equipment from potential contamination, and provide PPE for staff handling contaminated laundry. -Observation on 06/09/26 at 8:24 a.m., showed a medication aide (MA) (#6) prepared an inhaler medication, entered Resident #19's room, and without performing hand hygiene, administered the inhaler. The MA (#6) failed to perform hand hygiene upon entering the resident room and prior to administering the resident's inhaler.