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	04/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on observation, review of facility policy, and resident and staff interviews, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity and individuality for 1 of 15 sampled residents (Resident #6). Failure to honor the resident's request during cares and ensure staff speak respectfully does not promote the resident's self-esteem, preserve the resident's personal dignity, and may affect the resident's psychosocial well-being. Findings include: Review of the facility policy titled Quality of Life - Dignity occurred on 04/09/25. This policy, dated 2018, stated, . Residents shall be treated with dignity and respect at all times. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self -worth. Staff shall speak respectfully to residents at all times . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed . Review of Resident #6's medical record occurred on all days of survey. A care plan intervention, dated 03/11/24, stated, . Bladder scan every shift and PRN [as needed] per [Resident's name] request. An annual Minimum Data Set (MDS), dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observation on 04/07/25 at 2:45 p.m. showed two certified nurse aides (CNAs) (#18 and #20) and a nurse (#21) transferred Resident #6 from a wheelchair into bed in preparation for a bladder scan and toileting cares. The resident requested to have the bladder scan before the start of toileting cares. The three staff members failed to honor the resident's request and continued rolling the resident from side to side and placed a new brief. While rolling the resident to the side, one CNA (#20) stated, I am going to build muscles in my [slang word for breasts]. During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to honor Resident #6's bladder scan request and the CNA's statement during cares was unacceptable. During an interview on 04/08/25 at 3:39 p.m., Resident #6 confirmed hearing the comment made by the CNA (#20) and stated, I didn't think it was professional.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on observation, review of facility policy, and resident and staff interviews, the facility failed to ensure reasonable accommodation of needs regarding call lights for 1 of 15 sampled residents (Resident #6). Failure to place call lights within reach may result in an inability for residents to call for help, an increased risk for falls, and discomfort. Findings include: Review of the facility policy titled Call System, Resident occurred on 04/09/25. This undated policy stated, . Each resident is provided with a means to call staff directly for assistance from his/her bed . Review of Resident #6's medical record occurred on all days of survey. Diagnoses included quadriplegia. The care plan stated, . I use an easy call universal quadriplegic call bell [activated by a turn of the resident's head] or soft touch call bell [placed in the resident's hand] while in bed . An annual Minimum Data Set (MDS), dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observations on 04/07/25 of Resident #6's call bell placement showed the following: * 2:55 p.m. and at 3:07 p.m., a nurse (#19) exited the resident's room and failed to place the call bell within reach. The call bell laid in the seat of the wheelchair. * 3:30 p.m., a certified nurse aide (CNA) (#20) exited the resident's room and failed to place the call bell within reach. The call bell remained in the seat of the wheelchair. * Approximately 4:05 p.m., a CNA (#20) clipped the easy call universal quadriplegic call bell to the resident's pillowcase adjacent to his head and left shoulder and exited the room. The resident was unable to reach the call bell for activation with his head. When asked how often staff fail to leave a call bell within reach or accessible to him, Resident #6 stated, more often than not. During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to place the call bell within the resident's reach and ensure the resident can activate it.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 40488 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 15 sampled residents (Residents #4, #26, and #36). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2024, page A-32, stated, . Coding Instructions. Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . Review of Resident #26's medical record occurred on all days of survey. The record included diagnoses of psychosis, schizotypal disorder, bipolar disorder and psychophysical visual disturbances. A comprehensive MDS, dated [DATE], showed the facility failed to code Section A1510 for a serious mental illness. During an interview on 06/25/25 at 1:18 p.m., an administrative nurse (#1) confirmed staff failed to accurately code section A on Resident #26's MDS. SECTION H: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-3, stated, H0100: Appliances (cont.) Coding Tips and Special Populations. Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only . Review of Resident #36's medical record occurred on all days of survey and identified a supra pubic catheter. A physician's order, dated 02/03/25, stated, Indwelling Catheter . The quarterly MDS, dated [DATE], Section H0100 included coding for both an indwelling catheter and an external catheter. During an interview on 04/08/25 at 2:06 p.m., a corporate staff member (#15) confirmed staff failed to accurately code section H on Resident #36's MDS. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, page I-8, stated, . Active Diagnoses . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . medical treatments . during the 7-day look-back period . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's medical record occurred on all days of survey. A provider note, dated 02/11/25, identified a diagnosis of Parkinson's Disease and a new medication order for carbidopa-levodopa used to treat symptoms of the disease. The quarterly MDS, dated [DATE], failed to include an active diagnosis of Parkinson's disease. During an interview on 04/09/25 at 11:15 a.m., an administrative nurse (#1) confirmed staff failed to accurately code section I on Resident #4's MDS.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45873 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 6 of 15 sampled residents (Resident #2, #6, #16, #36, #43, and #47) dependent on staff assistance for personal hygiene and dining. Failure to assist residents who cannot perform personal hygiene, position self, or open items at meals may result in poor hygiene, skin issues, weight issues, and decreased self-esteem. Findings include: Review of the facility policy titled Fingernails/Toenails, Care of occurred on 04/09/25. This policy, dated 2018, stated, . The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Review of the facility policy titled Activities of Daily Living (ADLs), Supporting occurred on 04/09/25. This policy, dated 2021, stated, . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, . including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, nail care and oral care) . Dining (meals and snacks) . - Review of Resident #2's medical record occurred on all days of survey. The current care plan identified, . has ADL self-care deficit as evidenced by decreased mobility related to paraplegia . Observation on 04/06/25 at 1:46 p.m. showed Resident #2 had long, thick, yellow toenails. The resident stated, I need someone else to cut them [toenails], it's been a while since they have been done. - Review of Resident #6's medical record occurred on all days of survey. The care plan identified dependent on staff for personal hygiene. Observation on 04/07/25 at 10:15 a.m. showed Resident #6's toenails on both feet approximately one-fourth inch in length. During an interview on 04/07/24 at 2:36 p.m., Resident #6 stated facility staff clip his/her toenails occasionally. During an interview on 04/08/25 at 1:34 p.m., an administrative staff member (#16) agreed Resident #6's toenails needed trimming. - Review of Resident #16's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified moderate assistance required for personal hygiene. Observation on 04/06/25 at 2:25 p.m. showed Resident #16's fingernails extended beyond her fingertips. The resident stated, The nurse was going to cut them today but hasn't yet. They cut them about every two to three weeks. Observation on 04/07/25 at 3:27 p.m. showed Resident #16's fingernails remained untrimmed and dirty under the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #36's medical record occurred on all days of survey. Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness) following a stroke affecting the right dominant side. A quarterly MDS, dated [DATE], identified Resident #36 required ADL setup assistance for eating and dependent on staff for oral cares and personal hygiene. The current care plan stated, . should be upright in wheelchair for all meals to decrease risk for aspiration/choking. should receive consistent oral cares. I have physical functioning deficit . Personal hygiene: mod [moderate] A [assistance] . Eating: set up A, sitting up in w/c [wheelchair] during meals. Review of Resident #36's oral hygiene charting, dated March 9 - April 7, 2025 (30 days), identified staff provided oral cares one time a day for 12 days, two times a day for 12 days, and three times a day for six days. Observations of Resident #36 showed the following: * 04/07/25 at 8:49 a.m., seated in a wheelchair in his room and leaning to the left. A dietary staff member (#3) delivered the resident's breakfast tray and sat the tray on the bedside table in front of the resident but to his right side. The resident could not reach the items on the tray due to his inability to use his right arm and hand. * 04/07/25 at 12:06 p.m., seated in a wheelchair in his room and leaning to the left side with his left arm pressed against the wheelchair armrest. The resident stated an aide washed his face, but did not brush his teeth this morning. The resident stated staff do not help him brush his teeth with any regularity and have not yet today. Observation showed small yellow particles below his right eye and a brown dried substance on the corner of the left side of his mouth and down his chin. A sign above the bed stated, PLEASE!! complete oral care (brush teeth) after every meal, morning, and night. Thank you! At 12:08 p.m., a certified nurse aide (CNA) (#4) arrived with the resident's lunch tray, placed it on the bedside table, and removed the breakfast tray. The CNA failed to assist Resident #36 with hand hygiene or setup the resident's lunch tray. With his left hand, the resident tried to move the tray closer to him and attempted to open the milk carton. Observation showed his fingernails dirty with brown debris underneath them. The resident was able to get his right thumb into the top of the milk carton but failed to open it. The resident stated staff open the milk carton about half the time. The resident opened the milk carton about 20 minutes later by sticking his second and third fingers inside the milk carton. At 1:42 p.m., Resident #36 agreed to call for assistance when, after five minutes, he failed to remove a plastic cover from a dish of fruit. * 04/08/25 at 8:31 a.m., a nurse (#5) and a CNA (#6) repositioned Resident #36 in bed. The CNA raised the resident's head of the bed to 45-60 degrees, set up his breakfast tray, and opened the milk and yogurt cartons. The resident had difficulty reaching the items on his meal tray. At 09:02 a.m., the resident had not started to eat and stated, It would be good to sit up a little higher but he didn't want to call staff. An unidentified CNA arrived to assist the resident with cares, but the resident stated he would like to eat first. The unidentified CNA exited the room and failed to assist the resident with positioning and set up with his meal. At 9:14 a.m. (43 minutes after receiving the meal tray) this surveyor requested assistance for the resident and a CNA (#6) called for another staff member to assist her to position the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #43's medical record occurred on all days of survey. The current care plan stated, I have physical functioning deficit . Personal Hygiene: A x 1 [assistance of one staff] . An activities' note, dated 02/26/2025 at 10:30 a.m., stated, 1:1 [one to one] pamper and polish. Observation on 04/07/25 at 8:39 a.m. showed Resident #43's fingernails with dark colored debris under the end of the nails and at least half of the purple nail polish worn off the resident's left hand and no polish on the right hand. During an interview on 04/09/25 at 8:57 a.m., a CNA (#7) stated the CNAs provide resident cares and baths. The bath includes looking at their nails and clipping them as needed. - Review of Resident #47's medical record occurred on all day of survey. The current care plan stated, . I have impaired physical functioning related to: . L [left] sided weakness, impaired cognition . Observations for Resident #47 showed: * 04/06/25 at 4:30 p.m., teeth with a yellow-brown looking substance and white crust on the corners of mouth and fingernails on both hands long with a dark substance underneath the nail bed. An unlabeled basin containing a toothbrush was observed by the sink, and the other resident in the room identified the basin as mine. * 04/09/25 at 8:18 a.m., two CNA's (#8 and #9) assisted the resident with morning cares. The CNA (#9) assisted the resident to sink, could not locate a basin or toothbrush, and took a basin and toothbrush out of the roommates drawer with the roommates name written on the basin. The surveyor asked the CNA to identify the name on the basin. CNA (#9) stated, oh my mistake, and obtained a new basin and toothbrush for Resident #47. *04/09/25 at 10:50 a.m., observed an unlabeled basin containing a toothbrush on the sink in Resident #47's room. The CNA (#9) failed to label the basin. During interviews on 04/09/25 at 10:30 a.m. and 12:05 p.m., an administrative nurse (#1) stated she expected the CNAs to assist dependent residents with all ADLs. 28398 40488

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on observation, record review, review of facility policy, review of professional reference, and resident and staff interviews, the facility failed to provide the necessary care and treatment for 1 of 3 sampled residents (Resident #6) with impaired skin integrity and concerns of incontinence care. Failure to assess, monitor, and treat skin issues in a timely manner may have resulted in a delay of treatment and risk for further skin breakdown. Failure to provide routine incontinence cares (check and change) placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, and urinary tract infections. Findings include: Review of the facility policy titled Skin Breakdown-Clinical Protocol occurred on 04/09/25. This policy, dated 2022, stated, Evaluation and Recognition. the nurse shall describe and document/report the following . Full assessment including skin breakdown location, stage if applicable, length, width and depth . current treatments . The facility failed to provide a policy on the process/frequency of incontinence cares for residents who require check and change. 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 . 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 . Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 03/10/23, stated, Weekly Skin Assessments . every Wed [Wednesday] . The care plan stated, . has potential for altered skin integrity due to immobility and incontinence . conduct weekly skin inspection . I have a physical functioning deficit related to: limited mobility . Bed Mobility - Assist x3 [times three staff] . Toilet Use-Check and change assist x2 for pericares . Alteration in elimination of bowel and bladder r/t [related to] incontinence . History of recurrent UTI [urinary tract infections] . An annual Minimum Data Set (MDS), dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observation on 04/07/25 at 10:15 a. m. identified a purple circular area to the outer area/pad of the fifth toe on the left foot approximately a half inch in size, and red circular abrasion-type areas with a white open pin dot in the centers of the red areas located on the distal joints of the 1st, 2nd, 3rd and 4th left foot toes and the 2nd and 3rd toes of the right foot. An observation with an administrative nurse (#16) occurred on 04/08/25 at 1:34 p.m. The nurse (#16) confirmed the wounds to Resident #6's toes/feet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/25 at 12:58 p.m., an administrative nurse (#16) stated staff nurses complete and document the residents' weekly head to toe assessments. When a wound is identified, the nurses document it on the treatment administration record (TAR), and the wound nurse completes/documents measurements and weekly reviews. Review of Resident #6's weekly skin assessments lacked identification/documentation of the left and right toe/foot skin breakdown. Review of the resident's TAR and physician's orders failed to include monitoring and treatment of the toes/feet. During an interview on 04/06/25 at 3:56 p.m., Resident #6 stated the following: * Day [shift] will change me at the end of their shift [shift ends a 6:00 p.m.], and I won't get changed again until 11 [11:00 p.m.] or 12 [12:00 a.m.]. * The times I do put on my light [call bell] to be changed, they [staff] say, 'I will see if I can find somebody.' Then I get super soaked and they end up having to do a bed change and have to roll me around in bed. * I tend to be a heavy wetter. Review of Resident #6's check and change documentation record, dated March 9 through April 6, 2025, identified the following: * Thirteen days, check and change completed once in 24 hours * Eleven days, check and change completed twice in 24 hours * Four days, check and change completed three times in 24 hours * One day, check and change completed four times in 24 hours.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45873 Based on observation, record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #47) with weight loss. Failure to monitor/document intakes accurately and provide encouragement and assistance with meals and supplements resulted in a significant weight loss. Findings include: Review of the facility policy titled Weight Assessment and Intervention occurred on 04/09/25. This policy, dated September 2008, stated, . The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 3. The Dietitian will review the weight record weekly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. Provider will be updated with significant weight changes. Analysis . 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: . b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake . Interventions for undesirable weight loss shall be based on careful consideration of the following: a. Resident choice and preferences b. Nutrition and hydration needs of the resident c. Functional factors that may inhibit independent eating . f. Medications that may interfere with appetite, chewing, swallowing, or digestion . g. The use of supplementation . - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included diabetes and malnutrition. Physician's orders identified Mounjaro (a medication to lower blood sugar that may also cause weight loss) weekly on Fridays, Boost (liquid supplement) three times (TID) (8:00 a.m., 2:00 p.m., and 8:00 p. m.) and as needed (PRN) for malnutrition, and a regular diet, easy to chew texture, thin consistency. The current care plan stated, . I have impaired physical functioning . Eating: supervision for meals . Potential for or presence of altered nutrition needs altered ability to feed self . requires mechanically altered diet, impaired cognition . Diet and food texture provided as ordered . Encourage food and fluid intake . Record % [percent] of meals consumed . An addition to the care plan on 03/06/25 stated, I have weight loss r/t [related to] loss of appetite, eating < [less than] 50% of meals, potential medication side effects, disinterest in food/meals . Dietitian consult for caloric, hydration and nutritional intake needs, with recommendations for increased caloric needs . Offer high calorie/nutrient dense supplements as ordered by physician/dietitian . Weekly weights as ordered by physician . A review of Resident #47's weight record identified the following: *12/27/24 (admission) 188 pounds *01/26/25 173 pounds (7% weight loss in one month) *03/23/25 169 pounds (10% weight loss in three months) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	*04/06/25 150 pounds (11% weight loss in two weeks and a 20% weight loss since admission) Observation of Resident #47 occurred on 04/07/25 and showed the following: *9:00 a.m., staff assisted Resident #47 with the morning meal in the dining room. The resident refused the meal and drank half a glass of juice. The meal intake record identified the resident consumed 25-50% of the morning meal which differed from the observation. *10:30 a.m., a medication aide (MA) (#12) brought the scheduled 8:00 a.m. Boost to the resident's room, placed it on the overbed table, and failed to provide assistance/encouragement to drink it. *11:55 a.m., a full glass of Boost remained on the resident's overbed table. *12:20 p.m., the MA (#12) confirmed the Boost on the overbed table as the 8:00 a.m. supplement. Review of the medication administration record (MAR) identified the resident consumed 25% of the 8:00 a.m. Boost which differed from the observation of a full glass of Boost . An unidentified certified nurse aide (CNA) confirmed Resident #47 refused lunch, and two glasses of juice were noted on the overbed table. *3:45 p.m., a full glass and one half glass of juice, and a full glass of the 8:00 a.m. Boost remained on the overbed table in the same position as earlier. *5:00 p.m., a staff member took Resident #47 to the dining room. A full glass and another half glass of juice and the full glass of Boost remained in in the same position as earlier on the resident's overbed table. *5:05 p.m., Resident #47 seated alone at the dining room table. The paper menu in front of the resident stated, doesn't want to eat. The resident's meal included a scoop of ham salad, creamed carrots, glass of juice, and two gelatin cups. Staff failed to offer assistance or alternative menu items to Resident #47 during the meal. *5:40 p.m., an unidentified dietary staff member cleared the table, and stated Resident #47 was done eating. The resident ate one spoonful of ham salad, no carrots, one spoonful of gelatin, and drank the juice. Review of Resident #47's meal intake identified the resident consumed 51-75% of evening meal which differed from the observation. Observation of Resident #47 on 04/08/25 showed the following: *8:52 a.m., Resident #47 sat alone at the dining room table with a glass of juice three-fourths full. An unidentified dietary aide stated, [Resident name] refused his meal and did not eat. *11:55 a.m., the resident sat in a wheelchair in his room. A nurse (#5) called a CNA on the walkie talkie and asked if the resident ate. The CNA responded, He refused, we asked him a couple of times. Another CNA in the hall said, He never eats. Observation showed two boxes of Boost (one opened and full and the other unopened), and a full glass of juice on the resident's overbed table. Review of the MAR identified the resident consumed 50% of the 8:00 a.m. Boost supplement which differed from the observation. (continued on next page)

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	355024	A. Building B. Wing	04/09/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	*5:19 p.m., Resident #47 rested in bed. When asked if he was going to eat the resident replied No. Two boxes of Boost and a glass of juice remained on the bedside table as in prior observations. Review of the resident's meal intake identified staff documented 25-50% of the supper meal consumed; however, Resident #47 refused his meal. Review of the MAR identified the resident consumed 25% of the 2:00 p.m. Boost which differed from the observation. The MAR showed Resident #47 did not receive any PRN Boost on all days of survey. The Weekly Skin and Nutrition IDT [interdisciplinary team] Review, dated 03/27/25, identified a significant weight change of 10%. This assessment stated, Not eating well. Main intakes are supplements. Weight is stable over the past month. No new weight over the past week. Averaging 25-50% at meals . Diet: Regular . Supplements: Boost TID . Assistance/independence at meals: 1:1 [one to one] . Plan: Follow intakes and weight. No new weight this week. Will continue POC [plan of care]. Continue with Boost TID. Okay to drink supplement at meals if intakes poor. A nutrition/weight progress note on 04/03/2025 stated, Skin/Weight team met today to discuss resident. Resident continues to refuse food and prefers boost shakes, will continue to monitor per policy. Provider and resident updated. Resident #47's medical record lacked a dietitian's evaluation for the significant weight loss and current interventions or additional interventions to prevent further weight loss. The care plan failed to reflect the change to 1:1 assistance at meals as defined by the IDT. During an interview on 04/09/25 at 10:30 a.m., an administrative nurse (#1) stated she expected staff to accurately document meal intakes and observe and document percentage of supplements taken.

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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. 40488 Based on observation, review of professional reference, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen. Failure to ensure dishware is stored in a clean area and failure to ensure the floors and warewashing machine are free from food/dust debris has the potential for contamination of food and may result in a foodborne illness to residents, visitors, and staff. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, reviewed 01/08/25, Chapter 4-6, pages 20-21, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Observations on 04/09/25 at 10:30 a.m. showed the following in the main kitchen: * Loose debris and dust accumulated on the top of the mechanical warewashing machine. * Visible dry particles and debris on a tray of uncovered bowls located in a high traffic area of the kitchen. * Visible dry food/debris on the bottom of a cart used to store clean dishware. * An accumulation of food/dirt debris on the floor between the table legs of a stainless-steel counter and the wall in the dishwashing room. During an interview on 04/09/25 at 10:30 a.m., a dietary staff member (#3) confirmed the kitchen environment and floors should remain clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 28398 Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 8 sampled residents (Resident #2, #6, #8, #36, and #50) and one supplemental resident (Resident #15) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), perineal care, dressing changes, and hand hygiene, has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Enhanced Barrier Precautions occurred on 04/09/25. This undated policy stated, . EBPs employ targeted gown and glove use during high contact care activities . Examples of high-contact care activities requiring the use of gown and glove for EBP include . urinary catheter . wound care (any opening requiring a dressing). Review of the facility policy titled Dressings, Dry/Clean occurred on 04/09/25. This undated policy stated, . Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. Review of the facility policy titled Handwashing/Hand Hygiene occurred on 04/09/25. This undated policy stated, . Use an alcohol-based hand rub or . soap and water for the following situations: . after contact with resident's intact skin; j. After contact with blood or body fluids; k. After handling used dressings . After removing gloves . Findings include: ENHANCED BARRIER PRECAUTIONS - Review of Resident #50's medical record occurred on all days of survey. The current care plan stated, enhanced barrier precautions r/t [related to] an indwelling medical device catheter. A physician's order, dated 04/01/25, stated, CATHETER CARE: flush Foley catheter with 30mL [milliliters] NS [normal saline] every day shift for blockage/obstruction . Observation on 04/06/25 at 2:07 p.m. showed a red dot sticker on Resident #50's door frame indicating EBP and a supply container in the room containing personal protective equipment (PPE) including gowns and gloves. A nurse (#11) performed hand hygiene, applied gloves, and flushed Resident #50's foley catheter with normal saline. The nurse failed to apply a gown. - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, enhanced barrier precautions . A physician's order, dated 04/03/25, stated, L [left] heel unstageable pressure ulcer . change dressing every day shift . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/06/25 at 2:18 p.m. showed a red dot sticker on Resident #8's door frame indicating EBP and a supply container in the room containing PPE including gowns and gloves. A nurse (#11) performed hand hygiene, applied gloves, removed Resident's #8's left heel dressing, and discarded the dressing. Without removing the contaminated gloves, the nurse exited the room and obtained supplies from the top of the treatment cart located outside the resident's door. The nurse (#11) removed his/her gloves, performed hand hygiene, and completed the dressing change. The nurse failed to remove gloves and perform hand hygiene after removing the left heel dressing and failed to wear a gown during the dressing change. - Review of Resident #36's medical record occurred on all days of survey. The current care plan stated, [Name of Resident #36] is on enhanced barrier precautions per physician orders r/t [related to] an indwelling medical device - foley catheter. A physician's order, dated 12/21/24, stated, Change suprapubic catheter dressing daily . Observation on 04/08/25 at 8:31 a.m. showed a red dot sticker on Resident #36's door frame indicating EBP and a supply container in the room containing PPE including gowns and gloves. A nurse (#5) performed hand hygiene, gloved, and changed Resident #36's suprapubic catheter dressing. The old dressing had a scant amount of light colored drainage. The nurse failed to apply a gown to change the suprapubic catheter dressing. HAND HYGIENE - Observation on 04/07/25 at 9:24 a.m. showed two certified nurse aides (CNAs) (#6 and #8) applied gloves and a gown to assist Resident #15 with morning cares. The CNA (#8) completed frontal perineal care, removed his/her gloves, applied clean gloves, assisted the resident to use the mechanical lift, and placed the resident onto the toilet. The CNA (#8) performed perineal cares after Resident #15 had a bowel movement, removed his/her gloves, applied new gloves, adjusted the resident's clothing, applied foot pedals to the wheelchair, and combed the resident's hair. The CNA (#8) failed to perform hand hygiene after removing gloves and after performing perineal care. 31725 - Review of Resident #2's medical record occurred on all days of survey. A red dot sticker on the Resident's door frame indicated EBP. The current care plan stated, . [Resident name] is on enhanced barrier precautions per physician orders r/t [related to] an indwelling medical device . catheter . [NAME] [apply] gown and gloves during high-contact resident care activities . Observation on 04/06/25 at 1:46 p.m. showed a nurse (#13) entered Resident #2's room. The nurse, without performing hand hygiene, applied gloves, removed a band aid soiled with blood from the resident's toe, and with the same gloves, obtained a new band aid from her uniform pocket, and applied it to the open wound. The nurse (#13) failed to perform hand hygiene before applying gloves, obtained a clean band aid from her pocket with soiled gloves, and failed to remove the soiled gloves, perform hand hygiene, and apply clean gloves before applying a clean band aid to Resident #2's toe wound. The nurse (#13) also failed to apply required PPE (gown) before providing wound cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/06/25 at 1:55 p.m. showed two CNAs (#10 and #14) performed hand hygiene and applied a gown and gloves. The CNAs turned Resident #2 onto his/her side and removed the resident's brief. The CNA (#10) performed perineal care, and without changing gloves or performing hand hygiene, opened the resident's top nightstand drawer, obtained a tube of barrier cream, applied it to resident's buttocks over an open area of the skin, and placed it back in the resident's nightstand drawer. The CNA (#10) removed the soiled gloves, and without performing hand hygiene, applied new gloves and bagged linen from the resident's bed. The CNA (#10) failed to change gloves and complete hand hygiene between tasks and after completing personal resident care. - Observation on 04/07/27 at 3:37 p.m. showed a CNA (#20) assisted two other CNAs (#9 and #18) transfer Resident #6 from a wheelchair into bed and perform incontinence and perineal cares. After cares, the CNA (#20) removed her gloves, and without performing hand hygiene, obtained the resident's water mug, attempted to open the mug cover, and touched the resident's personal water pitcher. The CNA (#20) confirmed she failed to perform hand hygiene after removing her gloves and prior to performing other tasks. During interviews on 04/08/25 at 1:08 p.m. and 04/09/25 at 11:25 a.m., an administrative nurse (#1) stated she expected staff to wear a gown when flushing a foley catheter and doing a dressing change, and perform hand hygiene after removing gloves and prior to performing other tasks. 45873 40488 PERINEAL CARES Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 744, stated, . Retracting the foreskin is necessary to remove the smegma (thick, cheesy secretion) that collects under the foreskin and facilitates bacterial growth . Hold the shaft of the penis . securely in one hand. Clean the tip of the penis at the urethral meatus in a circular motion from the center outward and wash down the shaft . This follows the principle of cleaning from the least contamination to that of the greatest. Observations on 04/07/25 of Resident #6 showed the following: * 10:15 a.m., a CNA (#6) provided perineal cares for the resident while in bed. The CNA used a washcloth to cleanse the penis shaft and moved up to the penis tip. The CNA (#6) failed to retract the foreskin. * 2:45 p.m., a CNA (#18) performed perineal cares for the resident while in bed. The CNA (#18) failed to retract the foreskin. * 3:07 p.m., while performing straight catheterization preparation, a nurse (#19) retracted the foreskin, exposing a large amount of smegma. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to follow appropriate infection control practices during male perineal cares.