STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows on Fairview	25565 Fairview Avenue Wyoming, MN 55092

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 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** Based on interview and record review, the facility failed to ensure a non-pressure wound was comprehensively assessed for 1 of 2 (R12) residents reviewed for non-pressure skin concerns. Findings include: R12's admission Minimum Data Set (MDS) dated [DATE], indicated R12 had cognitive impairment and diagnoses of diabetes. Furthermore, R12 had a diabetic foot ulcer. R12's provider and nursing orders dated 3/10/25, directed staff to change R70's wound vac (device that provides negative pressure to wound to promote healing) on Mondays and Thursdays. R12's care plan dated 3/18/25, indicated R12 was at risk for pressure injuries due to presence of wound vac, neuropathy and diabetes with diabetic foot ulcer. Interventions included for staff to assess/record/monitor wound healing with wound vac dressing changes, obtain measurements, document status of wound perimeter, wound bed healing progress and report declines to the provider. R12's skin and wound evaluation assessment dated [DATE], was in progress and included wound measurements. However, the remainder of the assessment was blank. R12's skin and wound evaluation assessment dated [DATE], was in progress and included wound measurements and identified R12's wound to be a pressure wound present on admission. R12's electronic medical record lacked indication R12's wound had been assessed or measured other than 3/6/25 and 4/3/25. An interview on 4/15/25 at 1:06 p.m., registered nurse (RN)-A stated R12 had bone infection on the left foot and has had the wound vac in place since admission. RN-A stated the wound vac was changed on Monday and Thursdays and may need to get a wound picture updated. RN-A further stated there was no weekly documentation or measurements needed and had not been told that was needed. RN-A further stated documentation of it occurred in progress notes. When interviewed on 4/15/25 at 4:11 p.m., the Director of Nursing (DON) stated R12 had a diabetic ulcer and there had been some confusion with it being a pressure ulcer. DON further stated the facility did the wound cares and the podiatrist followed the wound. DON verified R12 did not have wound assessments or measurements completed weekly and would expect nurses to do that even with podiatry following. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. Building B. Wing	04/16/2025

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Meadows on Fairview	25565 Fairview Avenue Wyoming, MN 55092

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility assessment titled Management of Skin Alterations revised 9/11/24, directed residents with wounds will have weekly monitoring for appropriateness of treatment, signs of infection, pain or discomfort, and signs of healing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure tracking and surveillance was initiated and transmission-based precautions (TBP) implemented for 1 of 1 residents (R70) who was tested for clostridioides difficile, a highly contagious infection (C. Diff). The facility also failed to ensure proper hand hygiene was performed for 1 of 1 residents (R70) who was assisted with personal cares. Findings include: R70's admission Minimum Data Set (MDS) dated [DATE], indicated R70 was cognitively intact and had diagnoses of a femur fracture and heart failure. Furthermore, R70 required assistance of staff for toileting and was frequently incontinent of bowel and bladder. R70's provider order dated 4/14/25 at 7:00 a.m., instructed staff to send a stool sample for C. Diff. R70's bowel movement task sheet dated 4/2025, indicated R70 had diarrhea and watery stools mixed with soft stools. From 4/13/25- 4/14/25, R70 had only diarrhea. R70's care plan dated 3/29/25, indicated R70 required enhanced barrier precautions until incisions are fully closed and healed and instructed staff to gown and gloves during high contact care activity. Furthermore, R70's care plan indicated R70 required extensive assist with one staff for toilet transfers. R70's electronic medical record lacked indication R70 required TBP during the time R70 was tested for C. Diff. A facility document titled Infection Surveillance Monthly Report, dated 2/2025- 4/2025, lacked indication R70 was included for their loose stools and C. Diff testing. An observation on 4/14/25 at 12:05p.m., R70's door was open and R70 was laying in bed. Outside the door was a sign that stated Enhanced barrier precautions and directed staff to wear a gown and gloves with high contact cares. When interviewed on 4/14/25 at 12:05 p.m., R70 stated they were not feeling the best and their stomach was a little uneasy. R70 further stated the diarrhea had come back. R70 stated it was pretty bad when they first admitted , then seemed a little better, but now was back. An observation on 4/14/25 at 5:09 p.m., nursing assistant (NA)-A entered R70's room without donning a gown or gloves to deliver R70's dinner tray. NA-A then exited R70's room with a pink water cup and brought to a dirty dish area. An observation on 4/14/25 at 7:20 p.m., without donning gown or gloves, NA-A entered R70's room with a vital sign machine. NA-A did not don a gown or gloves. NA-A obtained R70's vital signs and then took their order for breakfast and lunch for the following day. NA-A then brought the vital machine out of the room and proceed back into R70's room. NA-A assisted R70 to their wheelchair. NA-A obtained gown and gloves before assisting R70 into the bathroom. NA-A told R70 the container in the toilet was for a stool sample and R70 can just go as she normally did. At 7:37 p.m., NA-A performed hand (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meadows on Fairview		STREET ADDRESS, CITY, STATE, ZIP CODE 25565 Fairview Avenue Wyoming, MN 55092	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hygiene donned a gown and gloves before entering R70's bathroom. NA-A removed R70's pants and placed them in a laundry basket. NA-A then placed a clean brief around R70's feet and assisted R70 to change into a gown for bed. R70 stood up with assistance and NA-A used several wipes to clean R70's bottom as R70 had a bowel movement. Without glove change or hand hygiene, NA-A pulled R70's brief up and assisted R70 back into the wheelchair. NA-A then removed gloves and without hand hygiene donned new gloves. NA-A then assisted R70 back to bed and removed 70's compression socks. The call light was placed near R70 before NA-A rinsed out the compression socks in the sink and hung on the grab bar in the bathroom to dry. NA-A removed gown and gloves and performed hand hygiene with hand sanitizer before exiting the room. When interviewed on 4/14/25 at 8:03 p.m., NA-A stated R70 was having loose bowel movements, and they were odorous. A sample would be sent to test for C. Diff. NA-A verified R70 was on EBP because of their surgical incision. Furthermore, NA-A verified they did not perform hand hygiene or exchange gloves after assisting with wiping and before donning new gloves. An observation on 4/15/25 at 7:27 a.m., R70's door had a sign that stated Enhanced Barrier Precautions and instructed staff to don a gown and gloves for high contact cares. Without gowning and gloving, NA-B entered R70's room and assisted to the bathroom. When in the bathroom, NA-B donned gloves and then assisted pulling R70's soiled brief down before R70 sat on the toilet. NA-B removed their gloves, gave privacy and closed the bathroom door. Without hand hygiene, R70 began to straighten out the pad, sheets and blanket of R70's bed. NA-B went into check on R70 in the bathroom. NA-B then knelt down near R70's feet and without gloves or gown, removed R70's soiled brief and placed in the garbage. Without hand hygiene, NA-B donned gloves and assisted with putting a clean brief and pants around R70's ankles and placed clean socks. R70 requested more time. NA-A removed gloves, performed hand hygiene with hand sanitizer and told R70 to put their light on before leaving the room. At 7:50 a.m., NA-B performed hand hygiene, donned a gown and gloves and entered R70's room. NA-B assisted R70 to stand and used a wet washcloth to clean R70's bottom. The washcloth was then placed on the counter next to R70's sink and a towel was obtained to dry. Without hand hygiene or glove exchange, NA-B pulled up R70's clean brief and pants before assisting to the wheelchair. NA-B moved R70 up to the sink to wash up. R70 initially grabbed the soiled washcloth and towel used to clean their bottom, however NA-B interjected and gave R70 a clean washcloth to use. NA-B finished up with morning cares and performed hand hygiene with hand sanitizer before exiting R70's room. When interviewed on 4/15/25 at 8:05 a.m., NA-B verified gloves and gown were not worn during all cares provided for R70. NA-B further verified no gloves were worn when removing the soiled brief and hand hygiene should have been completed after removing gloves and when moving from soiled to clean area. When interviewed on 4/15/25 at 1:17 p.m., registered nurse (RN)-A stated R70 had issues with diarrhea and had been given a supplement to try and bulk them up. After having the supplement for a few days, R70 continued to have loose stools on Sunday. RN-A left a message for the provider who ordered a stool sample to be checked for C. Diff on Monday. RN-A stated it was collected yesterday, but there had been no results yet. RN-A further stated R70 did not require any additional precautions right now because the test was not back yet. If R70's C. Diff test came back positive, R70 would need contact precautions which meant a gown and gloves were to be always worn when in the room and hand washing was needed instead of hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 4/15/25 at 3:37 p.m., the infection preventionist (IP) who was also the Director of Nursing Information was gathered from resident admission information, progress reports and other reports in the EMR. The IP further explained any resident who was started on an antibiotic had a case or line opened for them. This included their name, kind of infection, the antibiotic they were on, any symptoms, labs, and if TBP needed. IP stated only infections that were on antibiotics were included in the tracking system. Any potential infections were monitored by the nurses who would update the providers as needed. The IP expected TBP to be implemented when any resident had a pending test for a communicable disease such as C. Diff. IP verified there was a communication breakdown and had not been aware R70 had continued diarrhea and had been tested for C. Diff until the negative results came through today. IP further stated R70 should have been placed on contact precautions and staff should have used soap and water for hand hygiene once the C. Diff test was ordered. Furthermore, the IP expected staff to perform hand hygiene between each glove exchange and when moving from clean to dirty areas during resident cares. A facility policy titled Hand hygiene revised 4/2024, directed staff to utilize soap and water after known or suspected exposure to C. Diff. The policy further directed staff to change gloves during patient care when moving from a contaminated body site to a clean body site and to performed hand hygiene between any glove changes. A facility policy titled Transmission/Isolation Precautions revised 1/22/25, directed staff to review needs for precautions/isolation with IP or supervisor.