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	12/30/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review, review of facility policy, and staff interview, the facility failed to develop a baseline care plan to reflect the needs for 1 of 1 sampled resident (Resident #1) identified as a new admission. Failure to develop and implement a baseline care plan may result in inconsistent and unsafe care for all newly admitted residents. Findings include:Review of the facility policy titled Baseline Care Plan occurred on 12/30/25. This policy, dated 05/05/25, stated, . The baseline care plan will . be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident .Review of Resident #1's medical record occurred on all days of survey and identified an admission date of 12/10/25. The comprehensive assessment, dated 12/12/25, stated, . Transfer - assist x1 (assist of one) . Eating - independently . Toileting - assist x1 .The resident's base line care plan, dated 12/10/25, identified no interventions for specific needs such as transfers, eating, and toilet use. During an interview on 12/31/25 at 10:35 a.m., an administrative staff member (#1) confirmed staff failed to develop a baseline care plan for Resident #1.

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