DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 11, 2025

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: CCN: 245622
Cycle Start Date: April 16, 2025

Dear Administrator:

On June 10, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 11, 2025

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

Re: Reinspection Results
Event ID: NUVP12

Dear Administrator:

On June 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 16, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
April 30, 2025

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: CCN: 245622
Cycle Start Date: April 16, 2025

Dear Administrator:

On April 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 16, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/14/25- 4/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/12/25- 4/16/25, , a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		5/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2025

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.

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F 684	Continued From page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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 3/11/25, 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.	F 684	F 684 Quality of Care 1. Corrective Action: Resident R 12 was comprehensively assessed residents reviewed for non-pressure skin concerns. R 12 was discharged on 4/22/25. 2. Corrective Action as it applies to other residents: The policy on Management of Skin Alterations was reviewed and revised. Staff have been educated on the Management of Skin Alterations policy. Current residents with skin alterations were reviewed to ensure a comprehensive assessment of skin alterations are in place with appropriate interventions. Care plan reviewed and revised as appropriate. 3. Date of Completion: 5/23/25 4. Reoccurrence will be prevented by: Random audits of skin alteration documentation will be completed two times weekly for two months by the Director of Nursing or designee to ensure documentation has been completed. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by:	

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F 684	Continued From page 2 R12's skin and wound evaluation assessment dated 3/6/25, was "in progress" and included wound measurements. However, the remainder of the assessment was blank. R12's skin and wound evaluation assessment dated 4/3/25, 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. A facility assessment titled Management of Skin Alterations revised 9/11/24, directed residents	F 684	Director of Nursing or Designee	

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F 684	Continued From page 3 with wounds will have weekly monitoring for appropriateness of treatment, signs of infection, pain or discomfort, and signs of healing.	F 684		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/23/25

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F 880	Continued From page 4 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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).	F 880	F 880 Infection Prevention and Control 1. Corrective Action: Tracking and Surveillance was initiated for Resident R 70 for being tested for C. difficile. A C. difficile Toxin B by PCR completed on	

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F 880		F 880		

F 880

Continued From page 5

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 4/4/25, 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

F 880 (Plan of Correction)

4/14/25 and was negative. Resident R 70 was discharged on 4/19/25.
2. Corrective Action as it applies to other residents: The policies on Transmission Based Precautions and Hand Hygiene were reviewed and remain current. Resident charts were audited to ensure Tracking and Surveillance has been initiated for infection or suspected infection.
3. Date of Completion: 5/23/25
4. Reoccurrence will be prevented by: Reoccurrence will be prevented by: Random observational audits for hand hygiene will be completed two times weekly for a month by the Director of Nursing or designee. Random chart audits for infections and suspected infections will be completed two times a week for two months to ensure initiation of tracking and surveillance by the Director of Nursing or designee. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.
5. The Correction will be monitored by: Director of Nursing or Designee

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F 880	Continued From page 6	F 880		

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 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

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F 880	Continued From page 7 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	F 880		

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F 880	Continued From page 8	F 880		

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880		

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.

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

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F 880	Continued From page 10 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING ______	**04/16/2025**

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MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE** **WYOMING, MN 55092**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 16, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Meadows on Fairview, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING ______	**04/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE** **WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Meadows on Fairview is one wing of an assisted living facility that was constructed in 2004 and converted to nursing home in 2014. The building construction type has been determined to be Type V(111)). It is properly separated from the original building constructed in 2004 by 2 hour fire resistive construction, with 1.5 hour rated doors. The facility has a capacity of 14 beds and had a census of 13 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 04/16/2025, between 8:00 AM and 10:00 AM, observations and staff interview revealed that there was a penetration in the monolithic ceiling that had not been sealed. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Maintenance Director	K 311	K311 – Vertical Openings - Enclosure 1. Corrective Action: The unsealed penetration in the monolithic ceiling was immediately repaired and sealed with UL-rated firestop material on 4/17/25. 2. Corrective Action as it applies to other residents: A full inspection of the TCU ceiling areas was conducted by the Maintenance Director to identify any other penetrations or compromised fire-rated surfaces. No other deficiencies were noted. 3. Date of Completion: 5/23/25 4. Reoccurrence will be prevented by: Monthly ceiling and wall penetration checks will be conducted by the Maintenance Director or designee as part	5/23/25

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	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING ______	**04/16/2025**

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K 311	Continued From page 3 verified this deficient finding at the time of discovery.	K 311	of routine environmental rounds for two months. Any repairs will be documented and completed within 48 hours of discovery. 5. The Correction will be monitored by: Maintenance Director	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7,	K 353	K353 – Sprinkler System - Maintenance and Testing 1. Corrective Action: The documentation for Q3 2024 sprinkler system testing was located after the survey and has been forwarded to the fire marshal. A copy of the documentation has also been placed in the life safety log.	5/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING ______	**04/16/2025**

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K 353	Continued From page 4 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 8:00 AM and 10:00 AM, it was revealed by a review of available documentation that no documentation was presented to confirm that the sprinkler system testing was completed for Q3 - 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	2. Corrective Action as it applies to other residents: All fire protection system documentation for the past 12 months has been audited to ensure compliance and availability. No other documentation gaps were found. 3. Date of Completion: 5/23/25 4. Reoccurrence will be prevented by: The Maintenance Director will maintain a calendar system with reminders for all quarterly, semi-annual, and annual life safety system inspections. 5. The Correction will be monitored by: Maintenance Director	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for	K 920		5/23/25

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	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING ______	**04/16/2025**

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K 920	Continued From page 5 which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 8:00 AM and 10:00 AM, it was revealed by observation that there was a multi-pug adapter being used in the HVAC Closet and an extension cord being used at the nurses station. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 – Electrical Equipment – Power Cords and Extension Cords 1. Corrective Action: The multi-plug adapter in the HVAC closet and extension cord at the nurses' station were removed on 4/16/25. 2. Corrective Action as it applies to other residents: A facility-wide audit of all electrical outlets and devices was completed on 4/17/25. Any unapproved devices were removed or replaced. 3. Date of Completion: 5/23/25 4. Reoccurrence will be prevented by: TCU staff will receive re-education on power strips and extension cords. Random audits will be conducted once per month for 3 months to ensure compliance. 5. The Correction will be monitored by: Maintenance Director	

Electronically delivered
April 30, 2025

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

Re: State Nursing Home Licensing Orders
Event ID: NUVP11

Dear Administrator:

The above facility was surveyed on April 14, 2025 through April 16, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: ______ B. WING ______	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 4/14/25-4/16/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29463	(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

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2 000	Continued From page 1	2 000		

Continued From page 1

identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: 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 3/11/25, 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	2 875	CORRECTED	5/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: ______ B. WING ______	04/16/2025

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MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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2 875	Continued From page 3 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 3/6/25, was "in progress" and included wound measurements. However, the remainder of the assessment was blank. R12's skin and wound evaluation assessment dated 4/3/25, 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	2 875		

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2 875	Continued From page 4 R12 did not have wound assessments or measurements completed weekly and would expect nurses to do that even with podiatry following. 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could create policies or review and/or revise existing policies and procedures for wound monioring/documentation. The DON or designee could educate or re-educate nursing staff to those policies and procedures and conduct measurable audits The DON or designee could bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 875		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		5/23/25

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This MN Requirement is not met as evidenced by:
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.

CORRECTED

Findings include:

R70's admission Minimum Data Set (MDS) dated 4/4/25, 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.

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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 hygiene donned a gown and gloves before entering R70's

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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

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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

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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.

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.

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21385	Continued From page 10 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards and when to use implement TBP and hand hygiene. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		