STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores of Worthington	1307 South Shore Drive Worthington, MN 56187

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 51576 Based on interview and document review the facility failed to ensure alleged violations involving abuse/neglect were reported to the State Agency (SA) timely for 2 of 2 resident (R5, R7) reviewed for abuse/neglect. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE] identified severe cognitive impairment and dependent for dressing, grooming and hygiene. R5's care plan focus dated 12/5/24, identified R5 was at end of life and utilizing hospice. Interventions included coordinate care with hospice and other end of life services. During an interview on 12/12/24 at 8:43 a.m., hospice registered nurse (HRN)-D stated R5 was recently certified for hospice care. HRN-D visited R5 in the facility on 12/8/24 at 11:30 a.m. HRN-D reported when she entered R5's room, R5 was in bed and unresponsive, both eyes were matted shut and dark brown material on both corners of her mouth. HRN-D stated R5 appeared to be in same position she had placed her the day prior, R5's bed linens were soiled and incontinent pad on and was heavily saturated with urine. HRN-D did not inform the nurse on duty of her concerns due to being upset. During an interview on 12/12/24 at 3:04 p.m., HRN-D indicated she was not an employee of the facility rather employed by the hospice agency in which the facility had a contract with; she would be considered a contracted staff. HRN-D stated in the event of potential abuse/neglect she normally would report this to the nurse in charge, social service, or the director of nursing (DON). HRN-D stated the concerns she had for R5's cares on 12/8/24 were not reported to facility staff, social services, or director of nursing. During an interview on 12/12/24 at 1:35 p.m., the DON stated hospice was to report abuse/neglect concerns to the nurse on duty. During an interview on 12/12/24 at 2:50 p.m., Administrator stated his expectations for any hospice visit to report to the nurse on duty and if there were concerns, hospice staff would report this to the DON, who would share the concerns to the Administrator. (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: 245596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER The Shores of Worthington		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 South Shore Drive Worthington, MN 56187	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's face sheet dated 12/12/24, identified diagnoses that included amputation of right leg (removal of limb). R7's quarterly MDS dated [DATE], identified severe cognitive impairment and dependent for dressing, toileting, and transfers. R7's fall care plan dated 11/15/24 identified R7 was at risk for falls. Interventions to evaluate for fall risk on admission and as needed and if fall occurs, alert provider. Review of R7's incident report dated 11/30/24, indicated R7 had an unwitnessed fall on 11/30/24 at 2:00 p.m. , R7 was sitting on the floor next to her bed and did not have fall mat and bed at waist high position. R7 stated she had pain in her left leg. R7's progress notes dated 11/30/24 R7 was sent to emergency room (ER) for evaluation of left leg pain, x-rays were negative, and returned to the facility. Review of R7's incident report dated 12/1/24, indicated R7 had an unwitnessed fall on 12/1/24 at 4:35 a.m., R7 was found sitting on a mat near her bed and left leg bent in front of her. R7 was assessed and denied pain. However, progress notes on 12/2/24 identified R7 was sent to the ER due to left lower extremity became swollen, red, and painful. The ER called the facility to notify R7 was being sent to another hospital for broken leg and possible surgery. R7's progress note dated 12/3/24 at 11:36 a.m., identified hospital case manager called facility and stated R7 had a left tibia fracture, cellulitis, and abscess to left lower leg. R7 will be having surgery on 12/3/24. During an interview on 12/11/24 at 3:47 p.m., DON stated R7's fracture of left tibia was a serious injury and with having uncertainty of how it occurred, it should have been reported. Review of the facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy undated, identified if resident abuse, neglect, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator, director of nursing and the other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the facility Hospice and Nursing Facility Services Agreement dated 10/1/21 indicated hospice shall report to the facility all alleged violations involving mistreatment, neglect or verbal, mental, sexual, and physical abuse within 24 hours of hospice becoming aware which was inconsistent with the facility policy and federal requirements for reporting allegations of abuse and neglect. This polilcy was not consistent with the federal requirements for reporting allegations of abuse/neglect.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on interview and document review the facility failed to accurately comprehensively assess pressure ulcers in order to determine, develop, and implement individualized interventions to reduce the risk and/or prevent new pressure ulcers and/or deterioration of existing pressure ulcers for 2 of 3 residents (R3, R4) reviewed for pressure ulcers. Findings include Definitions: Pressure ulcer/Injury (PU/PI): localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Deep tissue pressure injury: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Stage 2 pressure ulcer: partial thickness loss of skin presenting as a shallow open area with a red or pink wound bed, without slough (a soft, stringy, white or yellow substance can appear in wounds and is made up of dead cells and other materials). May also present as an intact blister or open/ruptured serum filled blister. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 pressure ulcer: full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough maybe present but does not block the depth of tissue loss. Stage 4 pressure ulcer: full thickness tissue loss with exposed bone, tendon or muscle. Slough and eschar (a hardened, dead tissue It can appear black, brown, red, tan and may be fluid filled or crusty.) Unstageable pressure ulcer: slough and/or eschar present and covers the wound bed making it impossible to stage the wound. R3's admission Minimum Data Set (MDS) dated [DATE], indicated R3 did not have cognitive impairment with diagnoses of diabetes, arthritis, and dementia. R3 was dependent on staff for activities of daily living (ADLs) except for eating and used a manual wheelchair for mobility. R3 was at risk for pressure ulcers and had four stage 3 pressure ulcers present on admission with interventions of pressure reducing device for chair and bed, nutrition/hydration, pressure ulcer care, applications of non-surgical dressings and applications of ointment/medications other than to her feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan history identified care focuses, goals, and revisions since admission, however implementation dates were not identified. The care plan identified R3 had a documented pressure ulcer (did not specify location). Interventions included encourage resident to shift weight frequently, low air loss mattress, wheelchair cushion, reposition resident as allows, monitor ulcer for signs of progression or decline and provide wound treatment. R3's physician orders included wound treatments, however, also included heal protectors while in bed every night shift for offloading heels for wound prevention with a start date of 8/21/24. R3's wound records were reviewed between 10/8/24 through 12/6/24. The records included weekly wound assessments for multiple pressure ulcers varying in stages that were not consistently accurate nor comprehensive; one of which was a wound(s) on the right heel. The records indicated on 10/8/24 a large blister that ruptured on R3's heel was identified; the area deteriorated to two different pressure ulcers a stage 3 and an unstageable ulcer. Additionally, it was not evident the care plan was consistently evaluated and revised to include pressure relieving interventions to prevent or mitigate the risk of deterioration, prevention, or mitigation of risk there of. R3's progress note dated 10/8/24 at 1:31 p.m., identified during wound rounds on 10/3/24 two new darkened areas to R3's right outer foot, and a new area to R3's right inner foot. R3's heel is macerated, and heel is open and fragile. R3's Skin and Wound Evaluation dated 10/8/24, identified wound type as a ruptured blister that had started on 10/6/24, however, R3's record does not identify the presence of an intact blister and could not be determined when the blister ruptured. Further, the record did not address cause of the blister so appropriate pressure reducing interventions could be developed and implemented to prevent re-current blisters. Description included, no drainage, edges attached and macerated; the wound was healable. Intervention was suspension/protection device; it was not evident R3's care plan was revised. R3's corresponding photo of right heel dated 10/8/24, was not consistent with the evaluation. The photo identified a ruptured blister covering the bottom of the heel; the skin was macerated, crack or open area of the maceration from 12:00'oclock to 3:00 o'clock. Additionally, from 9:00 o'clock to 3:00 o'clock the underlying tissue was light purple which was not identified in the wound evaluation. R3's Skin and Wound Evaluation dated 10/11/24, identified shearing on right heel that started on 10/6/24 was described as shearing that measured 0.9 cm x 1.7 cm. Edges attached, fragile surrounding tissue, and improving. Interventions identified as heel suspension/protective device. It was not evident the care plan was revised. R3's corresponding photo was inconsistent with the evaluation dated 10/11/24. The photo identified sloughing skin from maceration and at the 10:00 o'clock to 12:00 o'clock position there was a dark red area. This area was not identified on the evaluation. During an interview on 12/18/24 at 9:31 a.m., director of nursing (DON) stated the wound type was not shearing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Skin and Wound Evaluation dated 10/20/24, identified wound on right heel was identified as a stage 2 pressure ulcer that measured 4.21 cm x 3.99 cm with no depth identified. No drainage, edges attached, calloused surrounding tissue, stable and healable. Interventions of cushion (was not specified), heel suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised with the aforementioned interventions. R3's corresponding photo of right heel, was inconsistent with the evaluation dated 10/20/24. The photo identified multiple dark purple areas that varied in size consistent with deep tissue injuries. These areas were not addressed in the evaluation. R3's physician progress note dated 10/22/24, indicated the wounds have extended in size, not improving, and now has maceration of the heel of the right lower extremity. R3's Skin and Wound Evaluation dated 10/25/24, identified wound on right heel was a stage 2 pressure ulcer with measurements of 0.64 cm x 0.69 cm. with no depth identified. Edges attached, surrounding tissue calloused, fragile, and improving. Goal of care was healable. Education: resident refused alternating pressure mattress. Interventions: suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised. R3's corresponding photo of right heel was inconsistent with evaluation dated 10/25/24. Photo identified 5 purple areas consistent with deep tissue injuries; one area had a whitish/yellow center. These areas were not identified in the evaluation. During an interview on 12/18/24 at 9:31 a.m., DON stated R3's wound on 10/25/24 should have been marked as a deep tissue injury and not a stage 2. R3's Skin and Wound Evaluation dated 11/2/24, identified wound on right heel was a stage 2 pressure ulcer that measured 1.5 cm x 1.13 cm. with no depth identified. 80% slough, 10% eschar, moderate serosanguineous drainage, edges attached, surrounding tissue calloused. Progress is stalled. Goal of care was healable. R3 refusing air mattress and prevalon boots. Interventions none. It was not evident the care plan was revised. R3's corresponding photo for 11/2/24 did not reflect the documentation. The photo identified the back of the heel had a reddened area and two purplish/red areas noted at the bottom of the heel that was not identified in the evaluation. R3's significant change Minimum Data Set (MDS) dated [DATE], indicated R3 had an increase in the number of pressure ulcers since admission MDS. R3 had one stage 2, and three stage 3, and one unstageable. R3's Skin and Wound Evaluation dated 11/8/24, identified the wound on right heel was stage 2. Wound measurements 1.27 cm x 3.45 cm with no depth identified. 100% eschar, moderate serosanguineous drainage. Progress is deteriorating. Goal of care was healable. Interventions of heel suspension/protection device (was not specified). It was not evident the care plan was revised. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's corresponding photo for the 11/8/24 evaluation did not reflect the documentation. The photo identified two open wounds: one on each side of the heel. It could not be ascertained which wound the documentation was entered for. The pressure ulcer on the right side of the heel was larger than the left side. Right: had an open area with a yellowish base/center, surrounding tissue was whitish with purple border. Left: had depth, whitish center, surrounding tissue either black or bluish (could not be further described because of the angle of the picture). R3's wound care nurse practitioner note dated 11/11/24, identified R3 was seen for an outpatient wound center follow up on 11/11/24 for right foot ulcer. Wound to right heel described as a Stage 3 with measurements of 1.5 cm x 1.2 cm x 0.2 cm. Ulcer base is 100% slough and near probe to bone. R3's Skin and Wound Evaluation dated 11/13/24, identified wound on right heel was a stage 2 pressure ulcer that measured 3.47 cm x 0.73 cm, no depth with 100% eschar, no drainage, edges attached, surrounding tissue calloused and stable. Interventions of cushion (was not specified) heel suspension/protection device (was not specified), moisture barrier, nutrition/dietary supplementation. It was not evident the care plan was revised. R3's corresponding photo for the 11/13/24 evaluation did not reflect the documentation. The photo identified two separate wounds both consistent with unstageable pressure ulcer. The evaluation did not identify which wound the description/measurements were for. During an interview on 12/18/24 at 9:31 a.m., DON stated after viewing image for 11/13/24, this should have been marked as an unstageable pressure ulcer. R3's Skin and Wound Evaluation dated 11/22/24, identified wound on left side of the right heel as a stage 2 that measured 2.0 cm x 1.85 cm x 0.4 cm. with 10% slough, 10% eschar, rolled edges, surrounding tissue fragile. Progress was deteriorating. Goal of care was healable. Note: both areas increased in size, unable to capture both areas in 1 picture, obtained separate pictures. Noted resident has increased pain while lying in bed do to contracture of right lower leg, appears to increase pressure to right heel. Area cleansed with normal saline Used Kerlix to secure gauze in place, whole roll used to offer some padding and is willing to wear prevalon boots. Interventions cushion, heel suspension/protection device, moisture barrier, moisture control. It was not evident the care plan was revised. The right pressure wound was described as an unstageable ulcer that measured 2.46 cm x 1.88 cm x 0.2 cm (even though the wound was unstageable) 20% slough and 20% eschar. R3's corresponding photo for the 11/22/24 evaluation for the right heel wound (left side) did not reflect the documentation. The photo identified two wounds right wound larger than the left. Left wound: open with macerated edges with dark purple area that was consistent with a deep tissue injury that surrounded almost 1/2 the wound; this area was not identified on the evaluation. R3's Skin and Wound Evaluation dated 12/1/24, identified wound on right heel was a deep tissue injury that measured 2.7 cm x 1.9 cm, 10% slough, 80% eschar, attached edges, dry/flaky and fragile. Wound was deteriorating. Interventions: cushion (was not specified), nutrition, and positioning wedge. It was not evident the care plan was revised. The corresponding photo was consistent with the wound description, however, was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Skin and Wound Evaluation dated 12/5/24, identified wound on right heel was deep tissue injury that measured 1.8 cm x 1.0 cm x 0.2 cm with 100% eschar, rolled edges, calloused, dry/flaky and fragile. The wound was stable and healable. Interventions included incontinence management and heel suspension/protection. The wound in the corresponding photo was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. It was not evident R3's care plan was revised however, physician order dated 12/5/24 directed prevelon boots to both feet. R3's Wound Care Clinic notes dated 12/6/24 identified Stage 4 pressure ulcer on right posterior heel acquired on 1/1/20 (conflicting information per previous facility wound assessments of start date of 10/6/24). Wound measurements are 2.2 cm x 2.0 cm, with no measurable depth with eschar. Right lateral heel identified as a chronic stage 2 pressure ulcer, acquired on 1/1/20 (conflicting information per previous facility wound assessments of start 10/6/24). Measurements 2.0 cm x 2.0 cm x 0.2 cm. Adipose tissue (body fat) exposed with slough and eschar. Wounds were debrided by provider. New orders for specialty bed/mattress for pressure reduction-keep pressure off right heel. R3's Wound Evaluation dated 12/12/24, identified wound on right heel was a stage 3 pressure ulcer that measured 0.45cm x 0.72 cm. no drainage, fragile surrounding skin, stable and healable. Interventions of heel suspension/protection device and nutritional supplement. During an interview on 12/18/24, DON stated the assistant director of nursing was monitoring the wounds and she noted there was inconsistency of the images and assessments of R3's wounds. DON indicated R3 developed the wounds from propelling herself in her wheelchair with her feet and she refused the blue boots. R3's interventions did not make it in her care plan. DON stated her expectation for any wound that are deteriorating was to have a new intervention place in the care plan. DON stated R3 was refusing dressing changes at times and the dressing changes done at different intervals. R4 R4's quarterly MDS dated [DATE], indicated R4 did not have cognitive impairment with diagnoses that included diabetes, coronary artery disease, renal insufficiency, and dementia. R4 had range of motion impairment to one side of her body and required partial to substantial assist with dressing upper body and dependent on staff for lower body dressing. R4 did not have a toileting program and was always incontinent of bladder and frequently incontinent of bowel. R4 was at risk for pressure ulcers but had none. R4 did have a diabetic foot ulcer she received application of dressing to feet with or without topical medication. R4 had pressure relieving devices in bed and on her electric wheelchair. R4's skin integrity care plan dated 6/12/24 indicated R4 had actual skin impairment related to incontinence and history of vulvar cancer. R4 had areas of MASD to right upper thigh, left gluteal cleft, coccyx, and left buttocks. R4's Skin and Wound evaluation dated 11/27/24, identified MASD/IAD to coccyx that measured 1.1 cm x by 0.3 cm and no depth documented. The area was in house acquired and new as of 11/26/24. The area was 100% granulation filled, no evidence of infection. Light amount of serous drainage without odor. The surrounding skin is dry and flaky, fragile skin at risk for breakdown. Notation of resident is on repositioning program, spends quite a bit of time lying in bed and up to recliner and power chair for short bits of time. Reminded resident to continue with repositioning. Staff educated on following resident care plan, repositioning every 2 hours and check and change. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's corresponding photo dated 11/27/24, identified an open slit on R4's coccyx. The base was yellow in color and the surrounding tissue was pink. This wound is not consistent with MASD and by definition is consistent with a stage 2 pressure ulcer. R4's Skin and Wound evaluation dated 12/5/24, identified MASD/IAD to coccyx measured 1.3 cm x 0.3 cm and no depth documented. There was 90% granulation and slough were present over 10% of the wound. There was no evidence of infection. The edges appeared flushed with the wound bed or as sloping edge. The surrounding skin looked fragile, at risk for breakdown. Treatment was to cleanse with soap and water and apply barrier cream. Area was noted to be improving. R4's corresponding photo dated 12/5/24 was not consistent with the evaluation. Photo identified an open slit in the coccyx with visible depth that was not assessed/documented on the evaluation. During an interview on 12/12/24 at 2:11 p.m., registered nurse (RN)-D stated assistant director of nursing (ADON), was responsible to review the quarterly care plans when she does the care conferences and was to make updates. RN-D was responsible for the annual care plan updates when she completed the annual and significant change MDS. RN-D further stated they had switched over to a different program and it did not allow them to make the care plans individualized. They had to use what was in the drop-down box. During an interview on 12/11/24 at 3:45 p.m., DON stated therapy decided the type of pressure relieving device or the wound care provider. All residents have a pressure relieving mattress throughout the facility. DON further stated her expectation was the residents care plan were updated with current interventions, so the staff knew what they were. Facility policy Pressure Injuries Overview 9/29/21, identified the purpos of the procedure was not provide information regarding definitions and clinical features of pressure injuries. The policy included the descriptions of pressure ulcers and associated terms used to desribe features of the pressure ulcer. This policy did not address components of a comprehensive assessment nor pressure relieving interventions. Facility policy Wound Care dated 9/29/21, indicated to 1) verify the physician's order for the procedure, 2) review resident's care plan for special needs, example: pain medication. Documentation included: 1) The type of wound care given. 2) The date and time the wound care was given. 3) The position in which the resident was placed. 4) The name and title of the individual performing the wound care. 5) Any change in the resident ' s condition. 6) All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7) How the resident tolerated the procedure. 8) Any problems or complaints made by the resident related to the procedure. 10) If the resident refused the treatment and the reason(s) why. Under Reporting 1) Notify supervisor if the resident refuses the wound care, 2) report other information in accordance with facility policy and professional standards of practice. 51576

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42355

Based on interview and document review the facility failed to complete comprehensive fall analysis and implement individualized interventions to prevent re-current falls and/or mitigate the risk for falls with major injury for 2 of 3 residents (R7, R5) reviewed for falls. The facility's failures resulted in actual harm for R7 when she sustained left tibial fracture that required surgical repair.

Finding include:

R7's face sheet dated 12/12/24 identified R7 had diagnoses that included acquired absence of right leg above knee and type 2 diabetes.

R7's admission Minimum Data Set (MDS) dated [DATE], identified R7 was admitted to the facility on [DATE] and had severe cognitive impairment with no signs or symptoms of delirium, behaviors or history of falls within six (6) months of admission. R7 had functional limitations in range of motion of one lower extremity, used a wheelchair, and was dependent on staff for hygiene needs, lower body dressing and chair to bed transfers. R7's ability to sit to stand and walk was not attempted due to medical condition. R7 was always incontinent of bowel and bladder, and administered insulin in addition to psychotropic, anticoagulant, and opioid medications.

R7's undated fall Care Area Assessment (CAA) included, resident currently has falls related to cognitive deficits and amputation of LRL (sic). Resident will have less than 2 falls per month through the review date. The CAA indicated and identified R1 was at risk for falls related to cognitive impairment, diagnoses of cardiac dysrhythmias, incontinence, loss of limb, anxiety disorder, schizophrenia, and the medications as identified in the admission MDS. The CAA indicated falls would be addressed in the care plan with the overall objective to avoid complications and minimize risks.

R7's fall risk evaluation dated 9/4/24, indicated R7 was at risk for falls with a history of three or more falls in the past three months. R7 was disoriented, chair bound/incontinent and was not able to perform gait/balance evaluation. The interventions listed were to evaluate for falls and if falls occur alert the provider.

Although R7's fall risk evaluation and the MDS identified R7 was at risk for falls, R7's care plan dated 9/4/24 did not include and/or address a plan of care for falls. R7's care plan dated 9/4/24 identified the following focuses and interventions:

-Current Functional Performance informed staff R7 required one person physical assist for toileting, for transfers R7 required total assist of two person with a full body mechanical lift using amputee sling.

-Impaired physical mobility related to amputation leading to phantom limb included but was not limited the direction of for staff to allow R7 adequate time for response and ensure call light available.

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NAME OF PROVIDER OR SUPPLIER The Shores of Worthington		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 South Shore Drive Worthington, MN 56187	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	-Documented Safety -Concerns directed staff to perform safety risk evaluations on admission, as needed, and upon change of condition and Safety Measures- including strategies to reduce the risk of infection, falls, injury initiated as appropriate. In review of R7's fall record between 9/5/24 through 12/1/24 identified R7 had 11 total falls. R7's falls incident reports identified the following: R7's fall incident report dated 9/5/24, at 5:25 a.m. indicated R7 had an unwitnessed fall in her room with no injury. R7 had been found on the floor next to her bed with blankets under her bottom, she appeared to have slid from the bed. R7 stated she needed to get up and use the bathroom so she wouldn't be late for school. The incident report identified predisposing factors as R7 was admitted within 72-hours and confused, but did not indicate/identify R7 had needed to use the bathroom as a factor. The report did not include comprehensive fall analysis nor identify immediate fall prevention interventions and not evident R7's care plan was revised. R7's fall incident report dated 9/7/24 at 4:51 a.m. indicated R7 who was wheelchair bound had an unwitnessed fall in her room with no injury. A nursing assistant (NA) had been completing the 30-minute checks and found R7 on the floor drinking water in good spirits with stool smeared on her floor mat. R7 had reported she wanted to get up and get her water. In response to staff asking how she got on the floor, R7 gestured her hand in a gliding motion towards the floor. Predisposing factors included R7 was admitted within 72-hours, but did not/indicate identify R7's bowel incontinence nor R7's location of water and/or need for water. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Furthermore not evident the care plan was revised to reflect the implementation of when/duration of 30-minute checks or usage of floor mat. R7's fall incident report dated 9/13/24 at 7:30 a.m. indicated R7 who was wheelchair bound normally does not ambulate at all had an unwitnessed fall. R7 was found sitting on the floor next to her bed and could not clearly inform staff if she hit her head or if her bottom hurt or not. Education provided to resident not get out of bed by herself but due to confusion instructions may not be understood. Predisposing factors identified included: confused, impaired memory, and incontinent. The report did not specify if R7 was incontinent when she was found. The report did not include a comprehensive fall analysis nor identify other fall interventions other than the immediate education that may not have been understood by R7. Further not evident of an assessment/evaluation to identify effectiveness of the education provided nor evident the care plan was revised to include resident education. R7's fall incident report dated 9/22/24 at 8:58 a.m. p.m. indicated at 5:25 p.m. R7 was in her room when an NA saw her pulling on the mattress, causing R7 to slide out of her wheelchair onto floor. R7 reported she had wanted to go to bed. Predisposing factors identified as confusion. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan was revised. R7's fall incident report dated 10/19/24, indicated R7 had a witnessed fall with no injuries at 9:30 a.m. when she appeared to be repositioning herself in her wheelchair and slid out of her chair landing on her bottom. Prior to the fall during breakfast, R1 had been agitated/behavioral and very confused. R7 Unable to give description. Predisposing factors checked were none, but noted mental status as alert and confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan was revised. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's fall incident report dated 11/3/24, indicated R7 had unwitnessed fall around 3:15 p.m. with no injuries. R1 was found by housekeeping staff sitting on floor, on her blue mat, leaning against her bed around 3:15 p. m. Prior to fall NA had just been in room, and found R7 sitting at the edge of the bed. NA assisted R7 back to bed and bed was in the lowest position. R7 was at her night stand and going through her stuff when she lowered herself to the floor. R7 unable to say what she was doing when she lowered herself to the floor but told family she was trying to get into bed. R1 was alert and confused. Predisposing factors included, confused and impaired memory. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident the care plan was revised to include appropriate bed height and usage of the floor mat. R7's care plan was revised to include a fall focus on 11/15/24, that identified R7 was at risk for falls however did not have individualized interventions that would prevent and/or mitigate R7's risk for falls including the usage of the fall mat, 30-minute checks, resident education, and bed height that was identified in the fall incident reports. The fall care plan only directed staff to evaluate for falls on admission and as needed and if a fall occurs, notify the provider. R7's fall incident report dated 11/26/24 at 1:40 p.m. indicated R7 had an unwitnessed fall with no injuries. R7's physician found R7 sitting on her floor mat. R7 reported she purposely put herself on the floor to get up. R7 was alert and confused. No predisposing factors were identified. Additionally, the report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/27/24 at 6:45 a.m. indicated R7 had an unwitnessed fall in her room, she was found sitting on her floor mat next to her bed. R7 appeared calm but was not able to state what happened. The fall resulted in a skin tear to left lower leg with minor bleeding. Predisposing factors identified as confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/29/24 at 7:00 a.m., indicated R7 had an unwitnessed fall and had an open area to her left shin. NA found R7 sitting on the floor mat next to her bed. The report included when asked why she was on the floor resident pointed to room mate. Then resident stated that she wanted to get up. The predisposing factor was identified as Resident is concerned about recent new room mate. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/30/24 at 2:00 p.m., indicated R7 had an unwitnessed fall. NA found resident sitting on the floor next to the bed. R7 was alert and confused. The bed was in waist high position with no fall mat next to bed. R7 reported her whole leg hurt when the nurse did range of motion (ROM). R7 was sent to the emergency room for further evaluation and the aide was provided with education on following the care plan. Predisposing factors included, confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's fall incident report 12/1/24 at 4:53 a.m. indicated R7 had an unwitnessed fall with no injuries. NA found R7 sitting on her floor mat next to her bed with her leg bent in front of her and incontinent of bowel, call light was in place and bed was in the lowest position. R7 was alert to person and place. Nurse had just been in her room at 4:35 a.m. to check on R7 since she was self-transferring from bed to the floor frequently. Predisposing factors identified as incontinent and R7 is very curious about roommate-wants to know what she is doing all the times. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's progress notes dated 12/2/24 at 7:02 a.m., R7 was sent to ER due to left lower extremity became swollen, red, and painful. At 11:54 a.m. the ER called the facility informing R7 was being sent to another hospital for broken leg and possible surgery. R7's emergency department note dated 12/2/24, identified a hematoma (collection of blood) to the proximal (near) the tibia/fibula are of left lower leg and a fracture of the left proximal end of left tibia and was sent to another hospital for surgery. R7's hospital discharge summary dated 12/10/24, identified R7 was admitted on [DATE] for a closed fracture of left proximal tibia that required surgery on 12/3/24, cellulitis and abscess of left lower extremity. R7 was discharged back to the facility on [DATE] on IV antibiotics. The records did not include and was not evident the facility completed a comprehensive fall analysis that identified potential causal factors and/or root cause(s) so that appropriate determinations for individualized fall interventions could be developed and implemented to remove R7's fall risk associated with the potential causal factors/root cause. R5 R5's face sheet dated 12/16/24, identified diagnoses of malnutrition (condition where body does not get enough nutrients), chronic kidney disease (condition where kidneys have been damaged), osteoarthritis (condition with joint pain and stiffness), and weakness. R5's quarterly Minimum Data Set (MDS) dated [DATE] identified R5 had severe cognitive impairment. R5 was dependent on staff for dressing, grooming and hygiene and required maximum assistance for all transfer. R5 had two or more falls with no injury and one fall with minor injury. R5's fall care plan dated 8/17/24, indicated R5 was high risk for falls related to weakness, history of falls with the following: Call don't fall signs posted in room, anticipate needs, call light within reach, physical therapy (PT) to evaluate and treat or as needed. R5's fall incident report dated 10/12/24, indicated R5 had an unwitnessed fall at 7:40 p.m. R5 was found in her room laying on her back next to walker. Predisposing risk factors included confusion and ambulating without assistance. Immediate action taken: R5 assessed with no injuries noted. [NAME] removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's fall incident report dated 10/13/24, indicated at 11:30 p.m. an NA witnessed R5 attempting to self-transfer in her room and was going to fall so NA assisted R5 to the floor. R5 stated I have to go I want to walk, can I go but she don't state where she want to go. No injuries were noted. Predisposing factors included confused, gait imbalance, using a walker, and alert but confused. Immediate actions taken: [NAME] removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/15/24, indicated R5 had an unwitnessed fall at 6:00 a.m. R5 was yelling and when NA entered R5's room, R5 was found sitting upright behind a closed door. R5 was confused and unable to give any detail of what happened but kept asking staff to lock the door. Resident has delusions of men coming into her room and keeps trying to shut the door. No injuries noted. Predisposing factors included alert and confused, gait imbalance, impaired memory incontinent using a walker, and wanderer. Immediate action taken: R5 assessed for injuries and placed in wheelchair and took to dining area for close observation. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/29/24, indicated R5 had an unwitnessed fall at 9:45 p.m., R5 had been in her bed and was found sitting on floor in front of wheelchair close to the bathroom, with gripper socks on, call light at bedside, and had been toileted within 30 minutes, no incontinence. R5 was unable to explain what happened. Predisposing factors included, confused. Immediate action taken: R5 was assessed for injury and noted to have bump on back of head. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. During an interview on 12/11/24 at 4:10 p.m., director of nursing (DON) confirmed causal analysis were not being completed and care plans were not revised. DON indicated she expected the facility policy be followed. After a fall occurs, a causal analysis was supposed to be completed and immediate interventions developed, implemented, and identified in the care plan. Review of the facility policy Falls, Clinical Protocol dated 10/4/2021, indicated the following: -Cause identification, 1) for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. the staff; 3) the staff and practitioners will continue to collect and evaluate information until either the cause of the fall is identified, or it is determined the cause cannot be found or is not correct. -Treatment/management, 1) based on preceding assessment, the staff and physician will identify interventions to try to prevent subsequent falls and to address the risk clinically significant consequences of falling. 2) if under lying causes cannot be readily identified or corrected, staff will try carious relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for it continuation. 51576

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 42355 Based on interview and document review, the facility failed to ensure 4 of 4 nursing assistants (NA-T, NA-D, NA-G, and NA-U) reviewed were deemed competent to complete cares for residents. This had the potential to affect all 45 residents residing in the facility. Findings include: Review of the facility job description Non-Certified Nursing Assistant (NA) and training requirements dated August 2021, indicated the primary purpose of this position is to provide resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisors. After completing facility competency training, all residents' lifts, transfers and activity of daily living (ADL) care, the non-certified aide must complete these tasks with the assistance of a facility Certified Nurse Aid (CNA). Review of NA-T's employee record indicated NA-T was hired on 9/10/24. NA-T's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-T's file did not include competency training records that identified NA-T was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 12:52 p.m., NA-T stated she was an uncertified nursing assistant and began working 2 months ago. NA-T stated she assisted residents with dressing, toileting, and assists with transfers with the mechanical lifts. NA-T stated she was registered for a nursing assistant course in June of 2025 and training was done by a certified nursing assistant and indicated she was not signed off for skills competencies. Review of NA-D employee record indicated NA-D was hired on 10/9/24. NA-D's file did not include an orientation record nor competency training records that identified NA-D was deemed competent for resident lifts, transfer, and ADL's. There were no competencies noted in NA-D's file for resident lifts, transfers and ADL's. Review of NA-G's employee record indicated NA-G was hired on 8/12/24. NA-G's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-G's file did not include competency training records that identified NA-G was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/10/24 at 3:51 p.m., NA-G stated he was an uncertified nursing assistant and began working in the facility about four months ago. NA-G stated he assisted residents with dressing, toileting and eating. NA-G stated he is not allowed to use the mechanical lifts. NA-G stated training was with a certified nursing assistant and indicated he was not signed off for skills competencies. NA-G further stated he was not currently enrolled in and NA classes and the next was not until February 2025 and he had not decided if he was taking that class. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of NA-U's employee file indicated NA-U was hired on 11/1/24. NA-U's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-U's file did not include competency training records that identified NA-U was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 3:45 p.m., director of nursing (DON) stated the assistant director of nursing (ADON) was to have performed competencies for all new employees before they worked on the floor. DON indicated competency records should be located in the employee file and if they were not then she was not sure where they would be kept. DON stated it was her expectation all new employees were competency tested prior to working on the floor and the record of the training/testing be kept in their employee file. The facility training program requirements were requested and not received.

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	245596	A. Building B. Wing	12/12/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 51576 Based on interview and document review, the facility failed to have a clear communication process between hospice and the facility of a change in hospice services to be provided and to designate a member of the facility's interdisciplinary team to coordinate care to the resident by the facility and hospice staff for 1 of 1 (R5) resident who received hospice services. Findings include: R5's face sheet dated 12/16/24, identified diagnoses of malnutrition (condition where body does not get enough nutrients), chronic kidney disease (condition where kidneys have been damaged), osteoarthritis (condition with joint pain and stiffness), and weakness. R5's quarterly Minimum Data Set (MDS) dated [DATE] identified severe cognitive impairment and dependent for dressing, grooming and hygiene. During an interview on 12/10/24 at 4:08 p.m., registered nurse (RN)-H reported that R5 was seen by hospice registered nurse (HRN)-D on 12/8/24. RN-H stated she did not receive any new recommendations about R5's plan of care from HRN-D during her shift. RN-H stated that hospice nurses normally notify the nurse on duty after visits and communicate any new recommendations. RN-H stated she did not inquire with HRN-D about R5's visit on 12/8/24. During an interview on 12/12/24 at 8:43 a.m., hospice registered nurse (HRN)-D stated R5 was admitted to hospice on 12/5/24 with a diagnosis of malnutrition. HRN-D visited R5 in the facility on 12/8/24 at 11:30 a.m. and stated she had told an unidentified nursing assistant that R5's plan of care changed and recommended R5 be turned, repositioned, and provided oral cares every two hours. HRN-D also indicated she had concerns pertaining to R5's care being completed. HRN-D did not tell the nurse on duty of her recommendations for the changes to R5's care plan nor communicate the care related concerns. R5's care plan focus dated 12/5/24, identified R5 is at end of life and utilizing hospice. Interventions included coordinate care with hospice and other end of life services. R5's care plan did not identify or a address a repositioning schedule and oral cares. During an interview on 12/12/24 at 3:04 p.m., HRN-D stated she typically would tell the nurse on duty of any changes she recommended but did not communicate this to the nurse on duty after R5's visit on 12/8/24. HRN-D indicated no documentation was recorded in the facility's electronic health record (EHR) about the change in plan of care for R5. During an interview on 12/12/24 at 1:38 p.m., RN-A stated she was not aware of a designated person in the facility that hospice was supposed to communicate changes, and that hospice nurse should report any concerns or changes in plan of care to the nurse on duty. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 1:53 p.m., RN-C stated that he was not aware of a designated staff member in the facility that hospice is communicate changes, and hospice nurses should talk to the nurse on duty. During an interview on 12/12/24 at 1:35 p.m., the director of nursing (DON) stated her expectations for any hospice visit would be that the hospice nurse would report to the nurse on duty any updates or changes. During an interview on 12/12/24 at 2:50 p.m., Administrator stated his expectations were for hospice to report to the nurse on duty and if concerns, they would report this to the DON, who would share the concerns to the Administrator. Review of the facility Hospice Program Policy (undated) identified facilities responsibility to communicate with the hospice provider to ensure that the needs of the resident are addressed and met.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51576 Based on observations, interview and documents review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 1 resident (R7). In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 2 residents (R7, R9) observed for handwashing/hand hygiene. Findings include: R9's Admission Minimum Data Set (MDS) dated [DATE], identified diagnosis of dementia and was dependent on staff for all mobility, grooming and hygiene. During an observation and interview on 12/11/24 at 10:16 a.m., R9 was in bed and nursing assistant (NA-N) and registered nurse (RN-F) were performing peri care for an incontinent bowel movement. RN-F did not perform hand hygiene prior to placing gloves on. RN-F removed R9's soiled pad, then completed incontinence cares on R9. RN-F placed soiled pad in trash, then removed gloves without performing hand hygiene. RN-F stated that hand washing/hand hygiene should be done before and after cares, and when hands are visibly soiled. RN-F stated she is aware that she did not perform proper hand hygiene while doing R9's incontinent cares. R7's face sheet dated 12/12/24, identified diagnoses of diabetes mellitus type 2 (a condition that affects how the body uses sugar) and cellulitis (potentially serious skin infection) of left leg. During an observation and interview on 12/11/204 at 11:56 a.m., R7 was in her room and RN-A was administering intravenous (IV) antibiotics through R7's IV catheter. R7's room had signage by the door indicating enhanced barrier precautions were needed. RN-A disconnected and flushed the IV after completion of infusion, RN-A was only wearing gloves and no gown. RN-A did not perform hand washing/hand hygiene after removing gloves. RN-A stated R7 was on EBP due to having an IV catheter and she also was getting wound care. RN-A stated EBP would be needed for any dressing, toileting, foley care, wound care and IV care. RN-A stated that EBP would not need to be used during just transferring a resident. During an interview on 12/11/24 at 3:47 p.m., director of nursing (DON) stated that EBP should be used for any resident with an IV, urinary catheters or wounds and her expectation is that if a resident is on EBP that staff would use the appropriate precautions for any physical touch of that resident. The facility policy on enhanced barrier precautions undated, identified that EBP is required for any for any resident needing device care, such as a central line. The facility policy on hand washing/hand hygiene dated 8/25/21, identified hand hygiene to be performed before moving from contaminated body site to clean body site during resident care.