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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores of Worthington	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to comprehensively assess and treat impaired skin integrity for 1of 1 residents (R3) who had acute dermatitis. Findings include: R3's face sheet dated 4/15/25, identified diagnoses of type two diabetes, obesity. R3's admission Minimum Data Set (MDS) dated [DATE], identified no cognitive deficits. Frequent incontinence of bladder and bowel. R3's care plan dated 3/25/25, identified R3 required extensive assistance with person hygiene and toilet use. R3's care plan dated 3/31/25, identified risk for impaired skin integrity and to monitor for moisture, apply barrier product as needed. A goal dated 4/4/25 included, skin integrity would be evaluated. Corresponding intervention directed staff to evaluate skin integrity. R3's hospital discharge orders dated 3/18/25, identified an order for bacitracin-neomycin-polymyxin 5-400-5000 milligrams (mg) unit ointment and apply 1 application twice daily to rash until clear. Clotrimazole 1% cream apply topically three times per day as needed, no diagnosis indicated. Hydrocortisone butyrate 0. 1% cream apply one application topically three times per day as needed for rash. Triamcinolone acetonide 0. 1% cream apply topically to affected areas twice daily as needed for atopic dermatitis. Interdry AG textile to opposing skin folds for prevention or treatment of irritated skin. Change every five days or if soiled. Leave a two inch tail outside of each end of affected area to wick away moisture. R3's physician orders dated 3/18/25 identified the aforementioned physician orders according to the hospital discharge summary. Review of R3's medication administration record (MAR) for March and April 2025, identified the treatment orders but there was no indication R3's skin care treatments were applied. The admission skin assessment dated [DATE] did not identify an issues with R3's skin. R3's progress note dated 3/18/25 at 1:29 p.m., identified the note as a nurse to nurse report from hospital. Under folds increased moisture and redness. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's progress note dated 3/19/25 at 12:22 p.m., indicated R3's rash had healed. R3's skilled evaluation progress note dated 4/9/25 at 11:43 p.m., identified no skin issues on abdomen or groin area. During an observation on 4/10/25 at 7:46 a.m., R3 was in bed. Nursing assistant (NA)-A filled basin with water and applied gloves to provide morning cares. NA-A removed R3's brief. R3's abdomen was reddened across the whole apron fold and groin area was very red on both sides. NA-A stated R3's abdomen looked a little sore/red across the whole abdominal fold and was very red in the groin area on the creases. NA-A then dried the areas she had just cleaned and applied a new incontinent brief. NA-A left the R3's room and returned to the room with an antifungal cream and an antifungal powder. NA-A stated she would use the antifungal cream as the area was not moist but leave the powder in the room also; she the applied antifungal cream to abdominal fold and groin creases. NA-A left the room, walked to registered nurse (RN)-A and notified RN-A that R3 was ready for a breakfast tray. NA-A did not mention R3's reddened folds. During an observation and interview on 4/10/25 at 12:20 p.m., registered nurse infection preventionist (IP)-A stated skin should be checked at a minimum weekly during a bath. NA's should be doing a daily check during morning and evening cares. A notable change should be reported to the nurse. IP-A explained R3 had been admitted from the hospital, the hospital had reported to the facility R3 had redness under folds and moisture, but the facility did not see that when he admitted . When the initial assessment was completed, the staff verify skin conditions, and the facility charting did not show concerns in that area. IP-A went to R3's room and put gloves on. IP-A lowered pants and lifted abdominal fold and stated that the areas were definitely red and moist. R3 indicated he had a history of problems in that area. This facility was not providing enough hygiene. The facility where he resided at prior and would be returning to had given him showers four times a week, had three times a week in a bath with jets, and used a medicated spray to manage the skin issues. This facility could not provide him with bathing due to his condition. IP-A stated the issue should have been reported to the nurse, medical doctor notified. The area needed to have the moisture removed to decrease redness. If this goes untreated it could lead to sores/infection. IP-A felt that a powder and Interdry would be a good treatment for the areas. Education should be done on cleaning and drying the folds as well. During an interview on 4/10/25 at 2:35 p.m., RN-A stated she looked at R3's skin after NA-A said to look at it because it was very sore. RN-A got busy and behind in work, IP-A also told her about R3's skin, and thought a fax was started to send to the physician. This was the first time it was reported to her that R3 had a red groin. RN-A explained skin issues would be documented under the skin section of the daily skilled charting notes. RN-A reviewed the record and identified there was nothing documented pertaining to the condition. RN-A relied on the NA's to tell her if a resident had new skin issues so that the area would be assessed. During an interview on 4/10/25 at 2:53 p.m., director of nursing (DON) stated the floor nurses have had education on what to look for with skin concerns. DON would expect the NA's to notify the floor nurse of a skin concern and the nurse would examine and determine next steps. DON was unsure if antifungal could be given as a standing order but typically would call or send a fax to the physician for orders. If care and treatment were provided improperly or not at all, nothing good could come of it. Improper treatment of wounds could lead to worsening wound(s) and if medications were given incorrectly, that could lead to a negative outcome. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/25 at 2:24 p.m., DON and IP-A stated there have been discrepancies between what the hospital reports and what the resident actually has when they enter the building regarding wounds and dressings. It was absolutely not appropriate and out of the scope of practice for an NA to choose what product to apply on a resident. The facility Wound Care procedure dated 9/29/21, identified to begin by verifying the physician order for the procedure. Document in the medical record: type of wound care given, all assessment data, etc. Report other information in accordance with facility policy and professional standards of practice.

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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** 49616 Based on observation, interview, and record review the facility failed to monitor and complete comprehensive skin assessments, evaluate the effectiveness of interventions, and provide physician ordered treatments as prescribed to prevent or negate the risk of deterioration or new ulcer development for 1 of 3 residents (R1) who was at risk for pressure ulcers and had a history of pressure ulcers. Findings include: R1's face sheet dated 4/9/25, identified diagnoses of obesity. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment. R1 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had frequent pain rated 10/10 with 10 as the worst pain ever experienced. R1 had a stage III pressure ulcer which indicated full thickness tissue loss. R1 had behaviors both verbal and physical directed at others, and rejected cares frequently. R1's wound evaluation dated 3/6/25, identified the stage III pressure ulcer to right ischial tuberosity was healed. R1's care plan dated 3/23/25, identified behavior management with interventions to attempt alternative time to provide care refused, monitor for signs and symptoms of infection. Pressure ulcer care dated 10/11/24, identified educate resident about proper skin care to prevent skin breakdown, encourage to frequently shift weight, provide skin care per facility guidelines, provide wound care per treatment order. Refused to sleep in bed and sleeps in the recliner per choice. R1's Braden scale for predicting pressure ulcer risk dated 4/8/25, identified a score of 13 which indicated moderate risk for pressure ulcers. R1's physician order dated 11/25/24, include the order to apply a mixture of calmoseptime external ointment mixed with collagen fibers to bilateral buttocks topically two times per day. R1's corresponding treatment administration record (TAR) between 3/6/25 through 4/10/25 identified the calmoseptime with collegene was marked as completed, however R1's record between 3/6/25 through 4/10/25 did not include corresponding assessments and monitoring of the area for which the treatment was being applied. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 demonstrated yelling behaviors toward all three staff during the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A sprayed peri-wash to the dried on bowel movement. RN-A began wiping bowel movement from both buttocks with wet wipes using her right hand. R1 stated his rectal area was very sore and to be careful. R1's bottom was noted to have many small, opened, red areas with bloody discharge on the right buttock and the left buttock had a heart shaped reddened area. RN-A stated they had some cream for that and squeezed a large amount of calmoseptime cream onto her right glove and rubbed it on bilateral buttocks pressure areas. RN-A did not mix the cream with collagen sprinkles nor measure the areas on R1's bottom. R1 began to scream and yelled ouch and I told you it was sore down there! NA-A took calmoseptime cream and squeezed some on right glove and put on creases of perineal region. NA-A removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink. During an interview on 4/10/25 at 11:17 a.m., RN-A stated the areas on R1's buttocks are moisture related sores. The treatment was to apply calmoseptime to the areas. A medical doctor had not looked at the areas but the DON would complete the assessments. In a subsequent interview on 4/10/25 at 2:35 p.m., RN-A stated she notified DON that R1's buttocks needed to be evaluated due to a change in the wounds. RN-A verified that collagen sprinkles were not used during wound treatment. RN-A was not comfortable with wounds and staging and would refer to DON on determining what treatment would be best and what stage a pressure injury would be considered. R1 is hard because when he yells it creates a rushed environment and steps get missed. R1's late entry progress note dated 4/10/25 created at 5:39 p.m. for 11:17 a.m., identified buttocks changed in appearance and current orders are for calmoseptime. Notified director of nursing (DON) and resident agreed to lay down after supper for wound picture. Corresponding wound assessments dated 4/10/25 at 6:15 p.m., by DON identified stage III (resolved stage III) pressure injury to right ischial tuberosity measured area: <0.1 centimeters (CM), length: 0.22cm and width: 0.31 cm, no depth was identified. Left ischial tuberosity stage III (resolved stage III) pressure injury area 5.87cm, length 2.42cm, width 2.96cm, no depth was identified. Wound orders updated to apply to both buttocks: cleanse with Vashe wound cleanser, apply collagen to open areas, cover with silicone bordered foam. Change every 3 days and as needed. During an interview on 4/10/25 at 2:11 p.m., RN-B stated moisture associated skin breakdown occurs when there is excessive moisture in an area. Once there is an area that has broken down it is more susceptible to breakdown. R1 is very adamant if he does not want to do something and the staff have to really try and coax him. RN-B would notify DON, and medical doctor if a change in wounds was noted. RN-B verified she was the nurse working with R1 on 4/9/25 and signed off that calmoseptime and collagen treatment had been completed. RN-B could not recall what condition the buttocks were in on 4/9/25 and did not remember looking at the wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated the DON completed weekly wound rounds on residents. Skin should be checked a minimum of weekly on bath days by the nurses. NA's should observe skin daily with cares and report changes to the nurse. Charting daily on the condition of wounds/wound dressing if the dressing is not scheduled to be changed is the expectation. R1 typically allowed the staff to transfer him from recliner to bed once a day. Every shift the staff encourage him to change positions. R1's current wound treatment was not appropriate for to treat R1's skin. The facility had wound training with a product specific company early in 2025 and they provided the facility with laminated cards for the NA's to direct what creams or lotions to use with specific skin issues. The DON has encouraged the nurses to come to her or the assistant director of nursing (ADON) if they were unsure about a wound. During an interview on 4/10/25 at 2:53 p.m., DON stated she observed wounds on residents weekly. RN-A informed DON to look at R1's buttocks as she was not confident in staging pressure ulcers. DON explained RN-A should have applied the treatment as ordered. Improper pericare could lead to infection and improper wound care could lead to worsening of wounds, both of which are negative outcomes. The facility Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 7/12/22, identified nursing staff and physician will assess and document an individuals significant risk factors for developing pressure ulcers. The physician will order pertinent wound treatments and help identify medical interventions related to wound management. The facility Wound Care procedure dated 9/29/21, identified to begin by verifying the physician order for the procedure. Document in the medical record: type of wound care given, all assessment data, etc. Report other information in accordance with facility policy and professional standards of practice.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to ensure appropriate care and services were provided to prevent urinary tract infections to the extent possible for 1 of 2 residents (R1) who had an indwelling urinary catheter. Findings include: R1's face sheet dated 4/15/25, identified diagnoses of overactive bladder (urgent need to urinate), atrophy of testes (shrinkage of one or both testes), benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms (frequent/urgent need to urinate). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment. R1 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had behaviors both verbal and physical directed at others and rejected cares frequently. R1's care plan dated 4/4/25, identified risk for urinary retention with foley catheter to be replaced monthly and as needed. Interventions included to evaluate for urinary complaints. R1 insisted that the catheter be placed. Monitor for abdominal distention and signs/symptoms of UTI. Evaluate for pain, urinary complaints, urine characteristics and cognitive changes. R1's physician order dated 8/30/24, identified an order for a urinary catheter 16 french 10 cubic centimeters (CC) balloon be placed, changed monthly with a diagnosis of urinary incontinence. R1's progress note dated 12/5/25, identified R1 returned from emergency department with a diagnosis of acute cystitis (inflammation of bladder often caused by bacteria) with hematuria (blood in urine). Start ciprofloxacin (antibiotic) twice daily for days. Maintain foley catheter with a 24 french 10 cc balloon. R1's physician order dated 1/5/25, included an order for 24 french catheter with 10 cc balloon. During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated she was unable to find specific culture results for the UTI but that R1 went to the emergency department for treatment on 12/5/25. R1's progress note dated 3/6/25, identified urine analysis and urine culture (UA/UC) results from 3/5/25 were positive for a UTI. Will treat with Keflex (antibiotic). During an interview on 4/10/25 at 12:20 p.m., IP-A stated the UC growth showed ecoli and enterococcis faccaeilis. Reviewed that these bacteria spread from direct or indirect contact with healthcare workers hands. R1's progress note dated 3/7/25, identified foley catheter changed, urine dark with sediment, when pulled out tubing tip was full of mucous. Located a 20 french with 30cc balloon, 24 french was not available as ordered by the physician on 1/5/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 4/4/25, identified UA/UC was ordered due to R1 having coke colored urine with blood present, and hallucinations. R1's progress note dated 4/5/25, identified UA was collected and ready to be sent to the lab. R1's record did not include the lab results. R1's progress note dated 4/7/25, indicated a physician order for Macrobid (antibiotic) two times a day for seven days started. Repeat UA in seven days. During an interview on 4/10/25 at 12:20 p.m., IP-A stated the bacteria that grew from the UC from 4/5/25, had multiple morphotypes present. IP-A went onto the computer and looked up what mulitiple morphotypes could be caused by and stated this bacteria can also be spread by direct or indirect contact with healthcare workers hands. During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 had yelling behaviors directed at staff throughout the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A wiped with her right hand in penile area and NA-B sprayed periwash on the dried stool dried on to and adheared to R1's bottom area. As NA-B cleaned the stool in an upward motion across R1's scrotum and by the catheter R1 yelled that it hurt. NA-A then took a wet washcloth and wiped on the groin creases and bowel movement was present on the washcloth. NA-A had NA-B rinse the washcloth in the filled water basin. NA-A took the same wash cloth from the basin and wiped the creases again. NA-A then moved to R1's penis and wiped around the catheter tip and then down the catheter tubing with the dirty washcloth. NA-A used a clean, dry towel to dry the areas. NA-A then moved the catheter tubing with her right gloved hand to move it out of the way while R1 was turned to his left side. Without changing gloves and santizing hands, NA-A took calmoseptine cream and squeezed some on right glove and put on creases of perineal region. NA-A then removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on without performing hand hygiene. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink. During an interview on 4/10/25 at 12:20 p.m., IP-A stated an investigation/analysis has not been completed nor surveillance activities such as audits in order to identify potential causal factors of R1's repeated UTI's so that interventions could be developed and implemented to prevent or reduce the risk. IP-A expected staff were to perform pericare following infection control guidelines. During an interview on 4/10/25 at 2:53 p.m., DON stated there had not been surveillance activities that addressed catheter related infections. If staff were not providing personal cares appropriately, that could lead to infection. DON and the ADON would be, but have not started, working on providing education and competencies with staff on catheter cares and pericares. During an interview on 4/11/25 at 11:36a.m., DON and IP-A stated the facility will increase fluids on residents with catheters. R1 preferred to drink mountain dew and was not good at drinking water. The nurses monitor for cognitive symptoms in R1 since the UTI he currently has, he was noted to have hallucinations as a symptom. Proper hand hygiene should be performed with pericares. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Urinary Catheter Care dated 11/1/21, identified to maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. It is not recommended to change the indwelling catheters or bags at fixed, routine intervals and instead based on clinical indications such as infection. Observe the resident for complications associated with urinary catheters.

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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. 49616 Based on observation, interview, and record review the facility failed to perform appropriate hand hygiene during cares for 4 of 4 residents (R3, R4, R5, and R10) observed for personal cares. Findings include: R3 R3's face sheet dated 4/15/25, identified diagnoses of intertrochanteric fracture of left femur (broken hip). R3's care plan dated 3/25/25, identified personal hygiene required extensive assistance from staff. During an observation on 4/10/25 at 7:46 a.m., R3 was in bed. nursing assistant (NA)-A filled basin with water and applied gloves. Cleansed top half of body and face. Had R3 turn to the side and wiped bowel movement with wipes. NA-A without performing hand hygiene, returned to the front of R3 and cleaned penis pulling down foreskin and wiping away white particles with a washcloth. NA-A then took off gloves and without performing hand hygiene left and returned to R3's room and without performing hand hygiene put new gloves on. NA-A instructed R3 to turn and washed bottom with wipe. NA-A then took the washcloth to remove the remaining stool from R3's bottom. NA-A put the washcloth in the water basin to rinse it out. NA-A then used that same washcloth from the dirty water and finished cleaning R3's bottom. While wearing the same gloves NA-A dried R3's bottom area and applied a new incontinent brief. Rinsed basin out in sink and emptied water into toilet. NA-A removed gloves and without performing hand hygiene gave R3 his call light and then washed her hands. R4 R4's face sheet dated 4/10/25, identified moderate intellectual disabilities. R4's care plan dated 8/20/24, identified R4 required assistance of two staff and mechanical standing lift for toileting. During an observation on 4/10/25 at 8:23 a.m., R4 was seated on the commode (portable toilet) with the mechanical standing lift attached. NA-A and NA-B applied gloves. NA-B lifted R4 into a half standing position with the machine while NA-A cleaned bowel movement from R4's bottom area. R4 stated that it was sore. NA-A stated she would put ointment on when finished wiping. NA-A moved to R4's front and wiped peri area with the same gloved hand used to wipe the backside. NA-A removed the glove after wiping, grabbed a tube of preventative ointment and applied to rectal area. Removed other glove and pulled up R4's pants and incontinent product. NA-A applied another set of gloves to clean commode. Removed gloves when finished. Both NA's washed hands at R4's sink. R5 R5's face sheet dated 4/10/25, identified fracture of upper and lower end of right fibula (broken calf bone), and fracture of medial malleolus of right tibia (the bump on the side of the ankle). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's care plan dated 4/8/25, identified R5 required assistance of two staff and mechanical lift for transfers. During an observation on 4/10/25 at 8:10 a.m., NA-A applied enhanced barrier precautions (EBP gown, gloves, mask) and entered room. NA-B was inside R5's room and opened the door. NA-B stepped out of the room and applied EBP. R5 was in the room attached to mechanical lift on the commode. NA-A and NA-B transferred R5 from the commode to the bed and removed the mechanical lift. NA-A wiped R5's bottom. Applied pants on R5's legs and incontinent product by rolling R5 side to side. Re-attached mechanical lift to R5. Transferred R5 to wheelchair and adjusted R5's shirt and boosted back in the wheelchair to R5's comfort. Gave R5 the call light and placed overhead table in front of wheelchair. Removed EBP and sanitized hands. R10 R10's face sheet dated 4/15/25, identified diagnoses of parkinsonism (difficulties with movement). R10's care plan dated 2/17/25, identified R10 required extensive assistance with personal hygiene. During an observation on 4/10/25 at 7:06 a.m., R10 was laying in bed. NA-C filled water in a basin.Applied gloves. Asked R10 to remove dentures so they could be brushed, removed and put in container to soak during cares. Washed face and abdominal region with soap and water after removing gown. After drying R10, applied a shirt. Opened brief and cleansed peri area. Grabbed another washcloth and cleaned backside. Put on a new incontinent product. Removed gloves and put a new pair on. Put a few gloves in her pocket. Put pants on. Had R10 sit on the edge of bed, put on socks, put walker in front of him. Transferred to wheelchair. Removed gloves and sanitized hands. During an interview on 4/10/25 at 8:36 a.m., NA-B stated that handwashing is done between residents. During an interview on 4/10/25 at 9:45 a.m., NA-C stated handwashing is done in the morning, on breaks, if bowel movements are bad and messy, otherwise hand sanitizer after exiting rooms. NA-C was unaware about handwashing between removing and applying new gloves. During an interview on 4/10/25 at 9:53 a.m., NA-A stated handwashing is used after coming in contact with a resident or leaving the room. It should be done between glove changes, I forgot. During an interview on 4/10/25 at 2:35 p.m., registered nurse (RN)-A stated hand sanitizing is done throughout the day, in between glove changes. Wash hands before and after cares. During an interview on 4/11/25 at 9:47 a.m., licensed practical nurse (LPN)-A stated management monitors, teaches, and reinforces hand hygiene and the importance of handwashing between pericare. During an interview on 4/10/25 at 12:20 p.m., registered nurse infection preventionist (IP)-A stated the staff should wash or sanitize hands after glove removal and should change gloves and sanitize or handwash after cleaning the peri area whether front or back. Staff should not clean bowels and use the same gloved hand or cleaning utensil to clean the front side. (continued on next page)

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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores of Worthington	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 2:53 p.m., director of nursing (DON) stated they [management] observe a ton of handwashing, applying and removing gloves that are a month or two old. Nothing good can come of improper peri care, it could lead to an infection. Hand washing and/or sanitizing should be done more often than it is apparently. We have been pushing staff to wash hands when removing gloves and use the sink, it is available in every room. If cleaning something dirty, remove gloves, wash/sanitize hands, put on new gloves, it is not worth it to cross-contaminate. The facility policy Perineal Care dated 2/8/22, identified the procedure was to provide cleanliness to the resident, prevent infections and skin irritation. For a female resident wash perineal area, wiping front to back. Wash the rectal area wiping from the base of the labia towards and extending over the buttocks. For a male resident wash perineal area starting with urethra and working outward. Wash rectal area thoroughly including under the scrotum, the anus, and buttocks.