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 03/04/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49336 Based on interview and document review, the facility failed to ensure the physician signed a Provider Order for Life-Sustaining Treatment (POLST) order for 1 of 15 residents (R37) following admission. Findings include: R37's 1/15/25, admission Minimum Data Set (MDS) identified R37 was cognitively alert and required substantial/maximal assistance with activities of daily living (ADLs). R37 had a diagnoses of malnutrition, anxiety, diabetes and cirrhosis. R37's 1/08/25 POLST, identified R37 was to be full code. There was no mention on the consent R37's wishes were communicated to the primary physician and was not signed within 30 days of admisson on rounds. Interview on 2/26/25 at 8:40 a.m., with Registered nurse (RN)-B identified residents POLST would be obtained during admissions with social service department and was to be signed by the primary physician and was to be updated on the resident medical record to ensure it matched admission orders and the resident had not changed or wished to change their status upon admission. Interview on 2/26/25 at 8:46 a.m., with director of nursing (DON) identified her expectation of POLST choices were to be addressed and documented when a resident was admitted to the facility by the physician. She voiced agreement that facility had failed to follow their policy, and the signed document had not been completed since R37's admission to the facility. Interview on 2/27/25 and 2:40 p.m., with admission coordinator identified R37's POLST had not been completed and was missed during admission. She identified it was not an acceptable practice for a R37 to not have a POLST in her medical record and was not aware R37's POLST was not signed by the physician on admission. Interview on 3/04/25 at 8:15 a.m., with medical director would expect residents code status to be determined and confirmed upon admission. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the October 2022 Advance Directive Policy identified the facility would obtain resident status on the POLST upon admission. The director of nursing or designee would notify the provider of advance directives or changes to the advance directive so that appropriate orders would be documented on a residents' medical record and plan of care. The facility would place residents advance directive document in an accessible location in the medical record.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R41) was accurately and comprehensively assessed when R41 exhibited behaviors or refusal of all cares, medication, treatment and evaluation. Findings include: Review of the Resident Assessment Instrument (RAI) 3.0 manual identified The RAI process has multiple regulatory requirements. Federal regulations require the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. In addition, an accurate assessment requires collecting information from multiple sources. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the interdisciplinary team (IDT) completing the assessment. R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. The MDS identified in section: 1) C: R41 was reported to answer cognitive questions to identify his mental status. 2) D: in the field D0100 Should Resident Mood Interview be Conducted the answer was checked yes however; no responses were given. D0500: Staff assessment of Resident Mood was blank. D0700: Social isolation was marked never. 3) E: Behavior: E0100 identified R41 had delusions. No behaviors were noted for physical, Verbal, or Other. Rejection of care was noted to only occur 1 to 3 days during the look-back period. E1100: Change in Behavior or Other Symptoms was left blank when asked how the residents current behavior status, care rejection, or wandering compared to his prior assessment. 4) F: Preferences for Customary Routine and Activities was not filled out. 5) H: Bladder and Bowel: H0300 identified R41 was occasionally incontinent. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6) J: Health Conditions: J0200 Should Pain Assessment Interview be Conducted? Answer is yes. J0300 Pain Assessment Interview/Pain Presence: Unable to answer was checked. J0800: Indicators of Pain or Possible Pain in the last 5 days: None of these signs observed or documented. 7) K: Swallowing/Nutritional Status: K0100 Swallowing Disorder/Signs and symptoms of possible swallowing disorder is related to observations of swallowing or reports of complaints of swallowing: None of the above was marked. K0200 Weight was documented as 191 pounds (lbs.). K0300 and K0310 mention weight loss and gain. Both are marked no or unknown. 8) L0200: oral/Dental Status: L0200 describes visualization of the mouth. No questions were answered. 9) M: Skin Conditions: M0100 Determination of Pressure Ulcer Risk: identified a formal assessment instrument or tool such as a [NAME] score and clinical assessment were checked as completed. M150 identified R41 was at risk for pressure ulcers. M0210: Unhealed pressure ulcers: Does the resident have 1 or more unhealed pressure ulcers at Stage 1 or higher? Answer was marked no. 10) P: Restraints: P0200 Alarms: subsection E: Wander/elopement alarm was marked with a 2 and noted to be used daily. Notes associated with the 2/25/25, MDS assessment in progress identified on 2/19/25, R41's: 1) Fall risk was evaluated. Staff documented he had no falls in the past 3 months. R41 was noted to have intermittent confusion. R41 was ambulatory and continent of bowel and bladder. Systolic blood pressure noted there was no drop between lying and standing. R41 was listed as having adequate vision and reportedly had no change of condition in the last 14 days. R41 had no hospitalization s in the last 30 days. His gait/balance was recorded as normal. R41 was noted to have taken 1-2 medications currently or within the last 7 days and had a fall score of 6. 2) Lift/Transfer Evaluation portion was completed. R41 was noted to be independent for cares and dressing. He was noted to not leave his room or have any locomotion on or off the unit. There was no indication how staff determined he was able to carry out tasks independently and/or safely. 3) Abnormal Involuntary Movement Scale (AIMS) (used to determine ill effects of anti-psychotic medications) identified R41 was noted to have no concerns with muscles of facial expression, no symptoms or effects affecting the peri-oral area (areas around the mouth), no abnormal movements of his tongue, and no abnormal movements with his upper or lower extremities. It is unknown how the facility had determined supporting facts for the assessment, since R1 had no vitals taken since admission or shortly thereafter, or how staff could determine he remained continent or had adequate vision without performing an assessment due to R41's numerous documented refusals. 4) Elopement evaluation was documented. R41 had a history of wandering at home and had no wandering in the facility noted. Notes associated with the 2/25/25, MDS in progress identified on 2/20/25, R41's: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Brief Interview for Mental Status (BIMS) was performed. Staff noted :Resident was unable to complete the interview and refused to answer questions. He Sits shaking his head no. 2) PHQ-9 score was evaluated. R41 was noted to answer No or had no response at all. 3) Social Services quarterly psychosocial quarterly note identified R41 continued to reside in a private room in the facility due to behaviors. Continues to refuse to communicate with staff. States You leave when approached to talk. Refuses most cares and medication. He refused his COVID screening and was placed on isolation, however staff noted he did not leave his room. FM-A calls often and states there isn't anything you can do to change his behavior. The social worker noted he was uncooperative with all assessments. He continued to talk about My father. Staff were unable to determine if the comment was related to religion or was part of a delusion. Notes associated with the 2/25/25, MDS in progress identified on 2/23/25, a Restorative Nursing Screener/GG Evaluation note was made. His ambulation was noted to not be able to be assessed. His self-care portion identified staff noted R41 was independent with eating, toileting, showering or bathing, and personal hygiene, but also identified R41 had refused the assessment. Notes associated with the 2/25/25, MDS in progress identified on 2/25/25, R41's OBRA Interim note was documented. Staff noted his functional limitations and range of motion (ROM) assessment identified he had no impairment. His Mobility and Ambulation portions in the note were documented as Not attempted. R41's Long Term Care Evaluation progress note (documented by the MDS nurse (RN-E)), identified the reason for the evaluation was a quarterly MDS assessment that was currently in progress. RN-E documented no falls since his last assessment occurred and no skin changes occurred. Vitals were listed as blood pressure (BP) 168/101 millimeters of mercury (mm/hg) obtained on 2/25/25 at 5:38 p.m. while R41 was seated, using his left arm. His oxygen saturation level (SpO2) was listed at 93% on room air. A vitals note was made Resident refused assessment. Vitals are from admission. I had to put something to close the assessment. R41's progress notes identified in September 2024, on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating my father , my father, my father takes care of me. My father tells me what to do and he says no touch. R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because God told him to. Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would need to go to behavioral health again. The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. Further review of R41's progress notes identified staff documented numerous refusals of all cares or assessment. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's September 2024 through February 2025 vital signs report identified vitals were obtained on 9/9/24. Of those vitals, R41 had 1 weight measurement on 9/9/24 of 191 lbs. No other weights were documented as obtained. R41 BP on 9/9/24 was listed at 168/101 mm/hg and his oxygen saturation (SpO2) was documented as 93%. On 2/25/25, the same date as the MDS note listed above, R41's BP and SpO2 readings were documented as the exact same as September 2024. No other vitals were obtained for R41 throughout his stay from September 2024 through March 2025. R41's bathing history was reviewed for the previous 30 days prior to the survey. At no time during February was R41 bathed. R41's assessment data history from September 2024 through March 2025 was obtained. R41 had only 3 assessments noted as completed. Those assessments were a [NAME] pressure ulcer risk assessment. One upon admission, one at R41's 11/21/24 quarterly assessment, and then R41's currently in progress 2/19/25, MDS assessment. No other assessments were documented for R41 from September 2024 through March 2025. R41's personal hygiene task for the last 30 days prior to survey was viewed. R41 was noted by staff to be completely independent with personal hygiene. It is unclear how staff determined this to be accurate and true. R41's behavior history task, documented by staff identified staff had checked R41 exhibited no behaviors of any kind. R41's March 2025. Medication and Treatment records (MAR/TAR) identified R41 had not received medications or treatments. Corresponding progress notes made by nursing staff in the medical record identified R41 refused all medications and cares. Interview on 3/03/25 at 11:28 a.m., with laundry aide (LA)-A identified LA-A had never washed any clothing for R41. She has never done R41's laundry since his admission. She assumed maybe his family washed his clothing. Observation on 3/3/25 at 11:30 a.m., of R41's room identified his door was open partially. R41 was observed to be standing in his room. Staff attempted to speak from the door. R41 waived his arm at staff to leave. No direct observations of R41 were able to be obtained. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/03/25 at 11:35 a.m., with RN-E related to R41 identified RN-E stated R41 refuses everything. When R41 was first admitted to the facility he would take his medication. Soon after he began refusing treatment or allowing staff into his room. R41 would tell staff god tells him he can't take his medication or that he doesn't need them. Some staff may be able to enter his room, but it is rare . it depends on the nurse aide. R41 always says get out!. Facility staff have spoken to FM-A and the MD. Essentially he isn't a risk for harm to himself or others He refuses medications that include antipsychotics. Staff are At a point with him .he is good living here . [staff] offer everything. When asked how RN-E or others assisting with the MDS assessments were able to perform assessments such as skin, she stated Staff cannot do skin assessments. She turns in MDS data based on what is able to be captured. Through the facility electronic program, designed to submit information to the Centers for Medicare and Medicaid (CMS) for payment, RN-E noted she had to put something in to the vitals section, or it would not allow her to close it within their system. RN-E stated her assessment data was based off what staff told her about R41, however did note that staff are not able to physically assess or often speak to R41 as he refuses staff entry most all days into his room when they try to either speak to him or provide any care at all, except to deliver meals. R41 allows that. RN-E agreed she is signing the MDS assessments to be accurate and true and acknowledged she is unable to accurately perform a comprehensive assessment on R41 and enters data in, so submissions are made. Interview on 3/03/25 at 4:26 p.m., with RN-A identified she was familiar with R41 and had even cared for him at the sister facility before it closed. RN-A stated R41 refuses everything. There are very limited staff who can interact with R41. He strikes out, kicks, and has verbal behaviors. R41 will not leave his room. She thinks R41 is continent or bowel and bladder, but acknowledged without being able to assess R41, there would be no way to know. Staff provide no cares or treatments for R41. RN-A was unaware if he even allowed linens to be changed on his bed or his clothing washed. RN-A had not seen R41's skin since he was administered Haldol in September 2024. RN-A was unaware staff were documenting R41 as having no behaviors, however, she related that to not being allowed to enter R41's room or provide any cares. RN-A recalled she has been unable to perform any assessments, give medication, or provide cares to R41 since September 2024. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified RN-E is responsible for MDS data collection and assessment. She was aware R41 refused all cares, assessments, or treatments. When asked how staff can accurately and comprehensively assess R41, she noted they cannot. Interview on 3/4/25 at 8:16 a.m., with the medical director (MD)-A identified he was unaware of R41's refusal of all cares. He would expect to be notified as he agreed R41 isn't capable of making an informed decision related to his health and safety. He was unaware R41 received no skilled nursing care, had only 2 baths, refused all meds, and had no laundry done. He was also unaware staff were unable to comprehensively assess R41. He agreed the assessment data included on the MDS would be false if staff could not actually assess R41. Review of the 2001, MDS/RAI Coordinator job description identified the purpose of that position is to conduct and coordinate the development and completion of resident assessment in accordance with the requirements of the state and the policies and goals of the facility. Part of the duties included to evaluate each resident's condition and pertinent medical data to determine the need for special assessment activities or the need to revise or amend the plan of care and to ensure all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions and be aware of penalties including civil money penalties for false certification.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47497 Based on interview and record review, the facility failed to accurately and thoroughly assess 1 of 1 resident (R40) for a history of trauma related to a diagnosis of Post-Traumatic Stress Syndrome (PTSD). Findings include: R40's 1/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she felt down, depressed or hopeless 2-6 days a week, and she displayed verbal behaviors directed towards others such as screaming, threatening, or cursing 1-3 days a week. R40 had a diagnosis of PTSD, anxiety, and a psychotic disorder. She was dependent on staff for all activities of daily living (ADL's). R40's 9/11/24, PTSD Resident Screening assessment identified the first question was: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide. R40 answered no. The facility assessment indicated if the answer is no, the assessor should stop there and not ask any of the additional questions. There was no indication the facility reached out to the emergency contact or family to try and identify the cause of the PTSD so the facility could be made aware potentially of any potential triggers and plan for that. Review of R40's care plan identified she becomes both physically and verbally aggressive during bathing and staff should administer medications as prescribed, encourage resident to verbalize cause of aggression, utilize diversion techniques, and allow personal space. The care plan made no mention that R40 had a history of an unknown traumatic event leading to a diagnosis of PTSD. Interview on 2/27/25, at 2:24 p.m., with social service designee (SSD)-B identified that she completed the trauma assessment with R40, she reported they had several challenges while transferring more than 30 residents into their facility from their sister facility that had closed. She could not recall specifically if she had reached out to the staff from the previous facility or to the family for information regarding R40's diagnosis of PTSD. She agreed they did not include anything on the care plan and was unable to find any documentation of anything that had been done to assess for triggers or appropriate care related to the diagnosis of PTSD. A policy was requested; however, none was provided by the end of the survey period.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687 Based on observation, interview and document review, the facility failed to notify the State Mental Health Authority ([NAME] County) for 1 of 1 resident with a diagnosis of major neurocognitive disorder with known behaviors and inpatient psychiatric stay 3 months prior to admission. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had diagnoses recorded of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R141's previous Preadmission Assessment Screening and Resident Review (PASARR) Level I was done previously at the now closed sister facility on 5/23/24, prior to R41's transfer to the facility. The questions answered at that time were: 1) Has this person had any of the following: A mental illness as a primary diagnosis for hospitalization within the past 2 years? Answer: No. Does this person have a diagnosis or symptoms of mental illness that has significantly interfered with functioning in life activities within the last 6 months? Answer: no. In the ADL's section Behavior was noted to require no intervention at that time. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's progress notes identified on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating my father , my father, my father takes care of me. My father tells me what to do and he says no touch. R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because God told him to. Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would need to go to behavioral health again. The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) 9/16/25 at 2:09 p.m., a call was placed to the primary care physician (PCP) nurse regarding R41's worsening and refusals of cares, medications, and meals. R41 had not allowed staff to touch him. R41 advised staff he was fasting for the entire month of September 2024. Staff expressed their concerns and asked for orders and suggestion. R41's PCP faxed back an order for staff to administer Haldol intramuscularly (IM) 5 milligrams (mg) every 4 hours x 2 doses. If no improvement, the order directed staff to send R41 to behavioral health again. R41's family member (FM)-A was called and stated to staff there was nothing they could do if he wouldn't take his medications .he would have to go back to the behavioral unit. FM-A gave permission for staff to administer the medication. 4) 9/16/24 at 2:47 p.m., staff attempted to enter R41 to speak with him about fasting. R41 began to scream at staff to get out of his room. The nurse attempted to educate R41 on the need for the injection and began screaming AHHHHHHHHHH NO injection!. R41 told staff he would not eat and is fasting for the month. He refused to allow staff to assess him and told staff to get out. The IM Haldol was given. 5) 9/17/24 at 10:12 a.m., staff noted R41 was in his room seated in his recliner. Staff offered food. R41 replied his food was poisoned. When staff attempted to interact with him, he raised his voice and told them not to touch him. He was upset staff gave him 2 injections (the previous day). The nurse tried to reiterate why R41 received the injections due to his delusions. R41 repeated more delusions such as I have intel. Another call was placed to R41's PCP. The PCP advised staff to proceed with a transfer to behavioral health. 6) 9/16/24 at 5:24 p.m., a call was placed for a non-emergent ambulance. EMS staff asked R41 questions and reported NO, I am normal .go away!. EMS identified R41 knew his name, and his location and had refused transfer. EMS told staff due to his ability to answer those questions, They were unable to take R41 to behavioral health as he was oriented correctly. EMS left without the resident due to his refusal for transfer. R41's PCP was updated. Numerous notes were made after 9/16/24, related to R41's ongoing refusal of all cares. 7) 10/1/24 at 10:47 a.m., staff noted they had called FM-A about R41's refusals of medication. Staff suggested discontinuing all medication as they felt it caused more behaviors. FM-A said lets do it. There was no indication staff had first checked with R41's PCP, behavioral health, or the medical director at that time on how they could best provide care and services to R41 prior to requesting family approval to discontinue medication. 8) 10/21/24, R41 was seen in house by contracted behavioral health services. A fax back after the visit was received with orders to administer Abilify (antipsychotic medication) IM and continue to try and give oral medications as he allowed. They also received a new order for as needed lorazepam (anti-anxiety medication) IM for agitation and severe anxiety and follow up every 14 days. Staff were instructed to contact the clinic with any concerns. 9) 10/21/24 at 11:25 p.m., a note was placed identifying R41 was seen in house by his PCP. No new orders were given. R41 refuses to take all medication. R41 was noted to be in his room all day and getting up only to use his bathroom. Staff noted no delusional behaviors. 10) 10/22/25 at 9:15 p.m., staff noted they had received electronically signed progress notes form the PCP. Staff noted they were unable to assess R41 or obtain vital signs. Per the PCP, they will return in 2 months to recheck. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes repeated the same inability of staff to provide care and services to R41. Review of a R41's physician progress notes identified on: 1) 10/22/24, the PCP noted diagnoses of agitation, depression, catatonia (group of symptoms that usually involve a lack of movement and communication, and can include agitation, confusion, and restlessness), chronic anemia (low iron), high blood pressure, liver disease, enlarged prostrate, mild persistent asthma, high cholesterol, and chronic obstructive pulmonary disease (COPD). R41's PCP noted he was followed by psychiatry. R41 refused everything including vital signs, examination and appeared to be quiet in his recliner. He was apparently in no pain but again refused to be touched or examined. The PCP noted it was a difficult assessment because patient refused talking to us and refused to be examined. The PCP directed staff to continue with his blood pressure medication (Amlodipine) if he accepted. Depression with catatonia, and combative behavior were identified with orders directing staff to continue Haldol every 6 hours as needed. No end date was given. Staff were instructed to give his lorazepam at bedtime, mirtazapine and Abilify (anti-depressant) and continue with escitalopram (another anti-depressant) and continue with his inhaler related to COPD as tolerated and accepted by R41. The PCP noted R41 was a difficult patient to take care of as he consistently refuses care .will return in 2 months to recheck should he allow us to examine him and check vitals. 2) The nurse practitioner (NP) documented R41 was refusing all cares. Will continue current medications as patient allows 3) 11/19/24, the PCP noted additional diagnoses from the previous visit of chronic hepatitis C, allergic rhinitis, elevated fasting glucose, pre-diabetes, and bilateral knee pain. R41 was noted to refuse everything namely examination, medications, some of his food, showering .basically spends his days on the recliner. Upon examination it was noted vitals signs were not taken because R41 refused. R41 made no complaints of pain or anything but refused his exam. Nurses reported he refused most of the time his food, although he ate some snacks, refuses showers, changing his clothing, medications, being touched, examined, or having his vital signs checked. The PCP reported they would keep insisting on seeing him without much hope. Psychiatry also tried to see him at the facility but patient refuses. The PCP was not changing anything with his medications as R41 was not taking it the times offered. He would return the next scheduled visit to see if there was improvement. 4) 1/21/25, the PCP returned for a facility visit. He noted R41 continued to refuse everything namely examinations, medications, some to most food, showering, and spent his day in his recliner. R41 would become aggressive when approached. R41 once again refuse exam and no vitals were taken. Nursing reported his refusals of care. The PCP's plan was no changes to medication as R41 wasn't taking them. The PCP noted he would continue attempts to see R41 on scheduled visits. Psychiatry had tried to see R41 several times, but he is able to provide his name, DON, and because of that, the PCP felt R41 could not be called incompetent to make decisions and noted psychiatry could not force the issue, neither can we. There was no indication the PCP had reached out to the medical director for guidance and his capacity to consent to refuse evaluated related to refusals of all care, most food and medication as a potential risk for harm without receiving appropriate care of services exists. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's 6/3/24, inpatient psych note from the Behavioral Health Hospital (BHH) identified R41 had diagnoses of catatonia, major neurocognitive disorder, altered mental status, and hypoxemia (lack of oxygen to the brain). R41 was identified to bat continued high risk/complexity secondary to the combination of acute on chronic psychiatric diagnoses, cormorbid medical illness, and use of multiple psychotropic medication. R41 had received electroconvulsive therapy (shock therapy) as an inpatient at the hospital. R41 had improvement there both physically and mentally. He was no longer catatonic after treatments with ECT and medication management. At that time, R1 was noted to be cooperative, well groomed and well nourished. R41 had no delusions, hallucinations, or paranoia with insight fair and improving. Upon his admission, R41 was an unreliable historian, had limited judgement in decision making in every day activities, social situations, and compliance for treatment. R41 had a previous BHH stay in April 2024, due to sever deterioration in functioning and concerns for catatonia. R41 failed to have the capacity to consent for decision making upon admission due to his mental health exacerbation. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified she was aware R41 refused all cares, assessments, or treatments. The facility was not required by State law to have updated PASARR Level 1 screening when they transferred residents from their now closed sister facility. The DON agreed staff should have had the county re-assess R41 for a Level II PASARR upon admission related to his mental health diagnosis and inpatient treatment he had 3 months prior to admission. No PASARR II policy was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38687 Based on interview and document review, the facility failed to ensure 9 of 15 sampled residents (R1, R5, R7, R8, R18, R20, R28, R41, and R42) care plans were developed and able to be revised as necessary. This has the potential to affect all 56 residents. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C, allergic rhinitis, elevated fasting glucose, pre-diabetes, and bilateral knee pain. R41's current, undated care plan identified R41 was noted to be independent with all Activities of Daily Living (ADL), and could transfer and perform personal cares independently. Staff noted in the Behavior Management focus the goals was for undesirable behaviors to be monitored and managed. Staff were to: 1) Attempt an alternate time to provide care if refused. 2) Educate R41 and his family (FM)-A of the necessity of care. 3) Ensure the safety of R41 and others. 4) Monitor for emotional factors that may contribute to new behaviors. No other interventions were noted or documented related to how staff were to provide appropriate care to R41 with repeated refusals of medication and care. There was also no mention of interventions for additional diagnoses listed from the PCP. Interview on 3/03/25 at 11:35 a.m., with RN-E, the MDS nurse identified the care plans used to be able to be individualized. Now they are canned or pre-programmed interventions. RN-E stated it was hard to individualize the care plans. RN-E agreed R41's increased behaviors were not care-planned, nor was his Hepatitis C. It does not allow for very accurate individualization of care plans. 39988 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8's Admission Record identified R8 was admitted in June of 2023 with the following diagnoses: stroke, peripheral vascular disease, overactive bladder, history of bladder infections, benign prostatic hyperplasia with urinary tract symptoms, long term use of anticoagulant, major depressive disorder, anxiety disorder, and atrial fibrillation. R8's 1/11/25, quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 had behaviors directed towards others, had other behaviors that were not directed towards others, and rejection of care that occurred 1 to 3 days during the assessment period. R8 was dependent on staff for most cares, R8 had an indwelling Foley catheter. Re had 1 stage 3 pressure ulcer and 2 unstageable pressure ulcers. R8 had 2 venous ulcers. R8 took a daily antipsychotic, antidepressant, anticoagulant, and opioid. R8's 2/26/25, Order Summary Report identified Xarelto 20 milligrams (mg) an (anticoagulant a blood thinner that prevents blood clots) one time a day for atrial fibrillation. R8 had a pressure ulcer on his right buttocks and sacral/lumbar region, and wounds on his bilateral lower extremities. R8's February Medication Administration Record identified R8 refused dressing treatments to wounds on lower extremity 12 times and other wound treatments for sacral and buttocks 15 times R8's undated, care plan identified R8 had pressure ulcers and staff were to educate on skin care to prevent skin breakdown. Staff were to encourage R8 to frequently shift weight and wear Prevalon boots while in bed or recliner. Staff were to provide wound care as ordered. There was no mention of a scheduled repositioning regimen to heal and prevent further pressure ulcers. There was no mention of what staff were to do if R8 refused wound care. R8 took Xarelto a blood thinner and there was no mention of the blood thinner on the care plan and what side effects staff should be monitoring for and reporting to the nurse. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident receiving medications such as anticoagulants that the nursing staff would monitor for side effects. Review of the 9/29/21, Wound Care policy identified that staff were to notify the supervisor if a resident refused wound care. R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission MDS assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 would have interventions should she have any signs of complications from dialysis occur through the review date. Staff were to encourage her to attend dialysis. Staff to monitor her intake. Staff to monitor and report sign or symptoms of infection to her access site. Staff were not to draw blood or take a blood pressure in arm with graft. The care plan lacked identification and location of her access sight to be monitored and of dialysis schedule or where R18 attended dialysis at. The care plan further lacked identification of nutritional status and diet to be provided. R20's Administration Record identified R20 was admitted in August of 2024 with the following diagnoses: hemiplegia, dementia with other behavioral disturbance, history of stroke, diabetes mellitus type 2, anxiety, and insomnia. R20's 2/14/25, quarterly MDS assessment identified R20's cognition was moderately impaired. R20 had no behaviors and required extensive assistance with most cares. R20 took pain medication, insulin, antipsychotic, antianxiety, antidepressant, antiplatelet, and hypoglycemic medications. R20's Order Summary Report identified R20 had his blood sugar checked one time a day before breakfast, R20 took insulin glargine (long acting) 25 units QD for type 2 diabetes and Metformin HCI 1000 mg twice a day for type 2 diabetes. Monitoring of R20's blood sugars located in his Medication Administration Record for February 2025, identified documentation of blood sugar as low as 60 and as high as 366. There was no mention of R20's normal blood sugar range or when the provider should be notified for further direction if blood sugars are low or high. R20's 2/5/25, care plan identified R20 was on a regular diet and would maintain adequate national status through the review date. The facility will provide and serve diet as ordered. There was no mention on R20's care plan that he was diabetic or for staff to monitor for hypo (low) or hyper (high) glycemia (blood sugar) and when to contact the provider for further guidance. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident diagnosed with diabetes that the nursing staff would monitor for signs and symptoms of hypo or hyper glycemia. R28's Admission Record identified R28 was admitted in January of 2021, with the following diagnoses: retention of urine, history of bladder infections, and chronic kidney disease. R28's 2/18/25, significant Minimum Data Set (MDS) identified R28's cognition was intact, she had no behaviors and was independent with cares. R28 had an indwelling catheter. Review of R28's 3/10/21, care plan identified R28 had an indwelling catheter related to urinary retention. Staff were to place a leg bag on in the morning and a drain bag placed at night. Staff were to use enhanced barrier precautions, monitor and document intake and output per facility policy. Staff were to monitor signs and symptoms of pain due to the catheter and for signs of infection. There was no mention of how staff were to care for the Foley catheter or how often staff were to provide catheter care. Interview on 3/3/25 at 11:24 a.m., with registered nurse (RN)-B confirmed that R28's care plan had no mention of providing catheter care and how frequently. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. 47497 R1's Medical Diagnosis list from 3/3/25, identified R1 had a diagnosis of chronic atrial fibrillation and acquired coagulation factor deficiency. R1's 12/17/24, significant change Minimum Data Set (MDS) assessment identified she admitted to the facility in September of 2024, her cognition was severely impaired and was dependent on staff for activities of daily living (ADL)'s. R1 was taking an anticoagulant. R1's March 2025, administration record identified she was administered Warfarin daily. Administration record made no mention that staff should monitor for signs or symptoms of bleeding related to use of an anticoagulant. Review of R1's undated care plan had no mention of anticoagulant use, signs or symptoms to watch for such as bleeding or bruising, or what and when to report to the nurse. R7's 1/31/25, significant change Minimum Data Set (MDS) assessment identified her cognition was intact. R7 reported she had little interest or pleasure in doing things, she felt down and depressed, and had no energy nearly every day. R7 had physical impairments on both sides and was dependent on staff for ADL's. She had diagnosis of diabetes, dementia, anxiety, depression, pressure ulcer to the right buttock and right heal. R7 used antipsychotics and antidepressants on a routine basis, she used pain medication daily. Continuous observation on 3/3/25, from 4:00 p.m. through 6:15 p.m. 4:00 p.m., R7 was seated in her wheelchair in the common/dining area at a table. She had pressure relieving boots on her feet the right boot extends to several inches below the knee, and the left boot was misplaced above the ankle, skin was visible below the boot. She had a cushion under her right elbow. Her legs were not elevated, her feet were on the floor and her chair did not have foot pedals. R7 had slid down in her chair and was leaning back with eyes closed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R7's 2/11/25, wound consultant note identified R7's skin to left and right heel is dark red, purple, blistered, and open. Open area to right heel medial is a stage 3, the area on the right heel is a deep tissue injury the right lateral foot is also a deep tissue injury, and the left heel is a deep tissue injury all are secondary to pressure. The wound consultant note identified that in addition to the current interventions in place staff were to implement scheduled repositioning every 2 hours. Review of R7's undated care plan identified R7 had a pressure ulcer and staff should keep skin clean, monitor ulcer for signs of progression or declination, provide wound care per treatment order and encourage her to frequently shift weight. Staff should reposition R7 as she allows. The care plan made no mention of how often staff should reposition her. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident receiving medications such as anticoagulants that the nursing staff would monitor for side effects, in addition he would expect residents who are at risk for or have a pressure ulcer would be repositioned or at minimum be offered repositioning on a scheduled basis. 49336 R5's 122/25, Significant Change Minimum Data Set (MDS) identified was cognitively intact and was dependent on staff with cares and was incontinent of bowel and bladder. R5 had a diagnoses of atrial fibrillation, diabetes, anxiety, depression. R5 had a unhealed, unstageable deep tissue pressure ulcer that was present upon admission/entry or re-entry and was to receive surgical wound care and application of dressing to feet. R5's, March Summary Report identified R5 was to cleanse the wound with normal saline, apply medihoney gel to both areas of the right foot and cover with foam dressing every 3 days and as needed. R5's current, undated care plan identified: 1) R5 had stage 3 pressure ulcer, and the goal was to promote wound healing. Staff nurses were to measure pressure ulcers regularly, monitor for signs and symptoms of infection and provide wound care treatment. 2) R5 had a right foot big toe amputation, as well as skin impairment to the lateral (side) of the 5th digit of R5's right foot. Staff nurses were to apply Prevalon boots to R5's foot in bed and in wheelchair, and to use caution for transfers and mobility to prevent striking R5's arms, legs, and hands against sharp surfaces. 3) R5 was at risk for activities of daily living (ADLS) and the goal was to monitor for R5's improvement. R5 was to ask for assistance from staff if R5 required repositioning or elevation to meet R5's needs to prevent injury. There was no mention on the care plan of R5's refusals of care or scheduled repositioning. R26's 1/08/25, quarterly Minimum Data Set (MDS) identified R26 had a moderate cognitive impairment and had a diagnoses of diabetes, hypertension, arthritis, and seizures. R26 had orders for insulin and received insulin during the last 7 days of the look back period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R26's, February Order Summary Report sheet identified R26's blood sugar was to be checked twice a day and was to receive glargine (long-acting insulin) 22 units subcutaneously (fatty layer between the skin and muscle) at bedtime. R26's current, undated care plan made no mention in R26's care plan of diabetes management, as well as, protocols for hyperglycemia or hypoglycemia monitoring. R37's 1/15/25, admission Minimum Data Set (MDS) identified R37 was cognitively alert and required substantial/maximal assistance with activities of daily living (ADLs). R37 had a diagnoses of malnutrition, anxiety, diabetes and cirrhosis. Upon admission, R37 had a stage 3 and stage 4 pressure ulcer and required non-surgical dressings to R37's bilateral feet. R37's, March Order Summary identified: 1) bilateral heel wounds was to be cleansed with Vashe (wound cleanser), apply purocol plus to wound bed, cover with dry gauze, secure with kerlix and ace wrap every 2 days. 2) apply betadine swabsticks 10% povidone-Iodine to right plantar (bottom surface of the foot) daily. R37's current, undated care plan identified R37 goal was to promote wound healing and staff nurses were to administer antibiotic therapy as prescribed and provide wound care treatments as ordered. There was no mention on the care plan of what wound care treatments was to be followed. The facilities 11/30/21, Care Plans, Comprehensive Person-Centered policy identified the comprehensive person-centered care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and incorporate risk factors associated with identified problems. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents condition change.

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 03/04/2025
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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47497 Based on observation, interview, and document review, the facility failed to revise 2 of 2 residents (R7 and R44) care plan after receiving new orders directing facility to ensure R44's legs were elevated as much as possible and to reposition R7 at least every 2 hours. Findings include: R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased swelling to her lower legs. The physician placed orders to add a water pill to decrease fluid in legs, and for staff to wrap her legs or put compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse and she identified she was not aware of the new orders but would check into it. R44's 2/19/25, physician order identified staff were to apply anti-fungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. Observation on 3/3/25 at 1:42 p.m., R44 was seated in her wheelchair with feet on the floor. She wheeled herself over to the closet and stood up to look at clothes, writer alerted staff. Nursing assistant (NA)-E went to R44's room and directed her to sit back down in her chair and then left the room. Interview on 3/3/25 at 1:47 p.m., with NA-E identified she had assisted R44 at 7:00 a.m., with morning cares and transferred her to her wheelchair. She identified that she had offered her to sit in a recliner around 10:00 a.m., but she refused. She reported the refusal to the nurse, she said the nurse told her to just try again in a little bit but reports she did not offer to sit in a recliner again. She reports that the nurse wraps her legs in the morning, the nurse would normally come in to put creams and powders on in the morning while the aids are doing morning cares, but she was not aware of anyone doing that today. She reported that normally new orders that would involve direct care staff would be passed on in shift report. It was passed on today about elevating legs but she did not hear anything about applying antifungal powder. Observation on 3/3/25 at 1:59 p.m., following interview with NA-E, she asked R44 if she would like to sit in a recliner, R44 said yes, and NA-E transferred her to the recliner and elevated her legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's undated care plan had no mention of lower extremity edema, wrapping legs daily, or elevating legs as much as possible. Interview on 3/4/25, at 8:47 a.m., with the facilities medical director identified he would expect staff to ensure care plans are revised to reflect the direct care needs of the residents as their condition changes. R7's 1/31/25, significant change Minimum Data Set (MDS) assessment identified her cognition was intact. R7 reported she had little interest or pleasure in doing things, she felt down and depressed, and had no energy nearly every day, she had no behaviors and did not reject care. R7 had physical impairments on both sides and was dependent on staff for ADL's. She had diagnosis of diabetes, dementia, anxiety, depression, pressure ulcer to the right buttock and right heal. R7 used antipsychotics and antidepressants on a routine basis, and was administered pain medication daily. Continuous observation on 3/3/25, from 4:00 p.m. through 6:15 p.m. 4:00 p.m., R7 was seated in her wheelchair in the common/dining area at a table. She had pressure relieving boots on her feet the right boot extends to several inches below the knee, and the left boot was misplaced above the ankle, skin was visible below the boot. She had a cushion under her right elbow. Her legs were not elevated, her feet were on the floor and her chair did not have foot pedals. R7 had slid down in her chair and was leaning back with eyes closed. 4:19 p.m., R7 remained in her wheelchair, awake, and in the same position. 4:30 p.m., R7 remained in her wheelchair, awake, and in the same position. She stopped several staff to visit with them, however, none of the staff offered to reposition her and did not prompt her to adjust her position in her chair. 4:50 p.m., she remained in her wheelchair, in the same position. The facility social worker designee sat next to her, R7 complained that her wrist hurt. 4:58 p.m., staff offered R7 pain medication for her wrist. 5:21 p.m., a NA brought a warm pack to R7 and placed it on her wrist. She did not offer to reposition her or encourage her to adjust her position in her chair. 5:24 p.m., Facility staff brought R7 her supper meal tray. R7 told staff she wanted to eat in her room, staff returned her tray to the cart. 5:28 p.m., staff are bringing her back to her room, R7's feet are dragging on the floor. They stop after about 20 feet and another staff assists by lifting her legs up and they bring R7 back to her room wheeling backwards. They were discussing that they cannot find the foot pedals for her wheelchair. Interview at 5:30 p.m., with nursing assistant (NA)-D reported R7 had another wheelchair that is larger, however, she does not like to use it unless she is going out for an appointment. She reports that she delivered her room tray and that it was unusual that she was out in the common area as she normally stays in her room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations continue: 5:35 p.m., R7 was in her room, she remained seated in her wheelchair. She was in front of her over-bed table and had her meal tray in front of her. 5:55 p.m., staff entered R7's room, nursing assistants asked her if she was going to eat anything, R7 told staff to take her tray. nursing assistant offered other food options, R7 agreed to try some pudding. The staff left the room. The nursing assistant did not offer to reposition R7. 6:15 p.m., R7 remained in her room, seated in her wheelchair. Staff were in and out of her room several times, however, they did not offer to reposition her. Interview on 3/3/25, at 6:15 p.m., With RN-B identified she was unsure how often R7 should be repositioned. She reviewed R7's care plan and identified she does not have scheduled repositioning. She reported she thought R7 had been up in her wheelchair since 1:00 p.m., she stated she had been out in the day room all afternoon. She identified that she would direct staff to reposition R7. R7's 2/11/25, wound consultant note identified R7's skin to left and right heel is dark red, purple, blistered, and open. Open area to right heel medial is a stage 3, the area on the right heel is a deep tissue injury the right lateral foot is also a deep tissue injury, and the left heel is a deep tissue injury all are secondary to pressure. The wound consultant note identified that in addition to the current interventions in place staff were to implement scheduled repositioning every 2 hours. Review of R7's undated care plan identified R7 required total assist of 2 staff for bed mobility, she had a pressure ulcer and staff should keep skin clean, monitor ulcer for signs of progression or declination, provide wound care per treatment order and encourage her to frequently shift weight. Staff should reposition R7 as she allows. The care plan made no mention of how often staff should reposition her. The facility provided policy Pressure Injuries Overview identified an avoidable pressure ulcer may be caused by not implementing interventions that are consistent with residents needs, goals, and professional standards of practice, monitoring or evaluation of the impact of the interventions or revision of the interventions as appropriate. The facilities 11/30/21, Care Plans, Comprehensive Person-Centered policy identified the comprehensive person-centered care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and incorporate risk factors associated with identified problems. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents condition change.

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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. 47497 Based on observation, interview, and document review, the facility failed to implement physician orders for 1 of 1 resident (R44). Findings include: R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased swelling to her lower legs. The physician placed orders to add a water pill to decrease fluid in legs, and for staff to wrap her legs or put compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse, and she identified she was not aware of the new orders but would check into it. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. R44's March 2025 medication administration record identified an order to apply ace wraps to bilateral lower extremities daily. The order entry date was 2/27/25, the order had been transcribed 8 days after it was received from the physician. Furosemide oral tablet 20 mg twice daily in addition to 20 mg for a total of 40 mg twice daily for 30 days transcribed on 2/21/25, 2 days after the order was received. R44's medication/treatment administration record lacked any direction for nursing staff to elevate lower extremities or to apply antifungal powder under abdominal folds. Observation on 3/3/25 at 1:42 p.m., R44 was seated in her wheelchair with feet on the floor. She wheeled herself over to the closet and stood up to look at clothes, writer alerted staff. Nursing assistant (NA)-E went to R44's room and directed her to sit back down in her chair and then left the room. Interview on 3/3/25 at 1:47 p.m., with NA-E identified she had assisted R44 at 7:00 a.m., with morning cares and transferred her to her wheelchair. She identified that she had offered her to sit in a recliner around 10:00 a.m., but she refused. She reported the refusal to the nurse, she said the nurse told her to just try again in a little bit but reports she did not offer to sit in a recliner again. She reports that the nurse wraps her legs in the morning, the nurse would normally come in to put creams and powders on in the morning while the aids are doing morning cares, but she was not aware of anyone doing that today. She reported that normally new orders that would involve direct care staff would be passed on in shift report. It was passed on today about elevating legs, but she did not hear anything about applying antifungal powder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/3/25, at 11:15 a.m., with RN-B and RN-D, identified their process is to review the new order upon receiving, transcribe the order, make a nursing progress note, and place the original copy in a wall pocket behind the nurses station for the medical records person to scan into the medical record. They identified the orders received following R44's 2/19/25 appointment had been transcribed late and the original order was not yet scanned into the medical record. RN-B reported they did not currently have a medical record person, and she was told they had planned to resolve that position, she stated nursing does not have time to scan all the orders in, she further revealed that they only complete a second check on narcotic orders and admission orders. Subsequent interview on 3/3/25, at 11:58 a.m., RN-B came to the conference room with the original order. She reported she found the order in a pile of papers that were waiting to be scanned in. R44's 2/19/25, original physician order identified staff were to apply antifungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. A facility policy for order transcription and implementation was requested but nothing was provided by the end of the survey period.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 39988 Based on interview and document review the facility failed to assess weight loss to determine the cause for 1 of 4 residents (R8) reviewed for nutrition. Findings include: R8's 1/11/25, quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 was independent with eating. R8 had behaviors and refused cares. R8 was identified to have a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. R8 was identified for weight loss that was not a physician-prescribed weight -loss regimen. R8 did not have a therapeutic diet. Section L Oral/Dental Status of the assessment was not completed. R8 had pain and took scheduled pain medication. R8 had one stage 3 pressure ulcer, two unstageable pressure ulcers and tow venous ulcers. R8's 2/26/25, Order Summary Report identified R8 was on a regular diet with regular texture. R8 was to be weighed monthly. R8 took Arginade Powder 1 packet by mouth one time a day for wound healing. There was no mention that R8 was on a supplement related to weight loss. R8's Weight Summary report identified R8's weights as follows: 8/14/24 weight 273.0 pounds using wheelchair 9/4/24 weight 270.6 pounds using wheelchair 9/7/24 weight 245.6 using mechanical lift -with a message that there had been a 10% weight change compared to 4/5/24 of 282.4 pounds, a 7.5% weight change compared to 7/5/24 of 273.4 pounds, and a 5% weight change compared to 8/14/24 of 273.0 pounds. 9/14/24 weight 245.4 pounds using mechanical lift 9/18/24 weight 246.9 pounds using mechanical lift with message that there had been a 10% weight change compared to 4/5/24 of 282.4 pounds, a 7.5% weight change compared to 7/5/24 of 273.4 pounds, and a 5% weight change compared to 9/4/24 of 270.6 pounds. 10/7/24 weight 246.9 pounds using mechanical lift 10/9/24 weight 247.5 pounds using wheelchair 10/23/24 weight 247.0 pounds using mechanical lift 11/7/24 weight 243.8 pounds using mechanical lift 1/8/25 weight 240.2 pounds using mechanical lift 2/7/25 weight 240.0 pounds using mechanical lift (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nutritional progress notes identified: 10/22/24, dietician note for a follow up for weight change and skin issues. R8 was tolerating a regular diet and was independent with eating. R8 ate 25-75% of his meals and was a picky eater. Recommended Arginade supplement 1 packet for would healing. Noted weight changes and requested re-check of his weight. 1/9/25, dietary manager note R8 was on a regular diet. Have visited with R8 about his intakes and R8 will tell dietary manager to just go. Intakes were 25-75 % and resident had snacks in his room. Will continue to monitor and encourage intakes. 2/12/25, dietary manager note R8's average intake was 50-75%. Will continue to monitor. Interview on 2/26/25 at 8:53 a.m., with the dietary manager identified R8 was weight when he allowed. She had visited with him about meals, and he will answer what he wants. She confirmed she was aware that R8 had lost at least 10% in the last 6 months as the electronic medical record point click care (PCC) flags a warning when there is a discrepancy in the weight. She reported that the dietician would review the weight loss and contact the provider with recommendations or have the nursing department do that. She was unaware if the provider had been notified of R8' s weight loss. She revealed the dietician had not assessed R8 in a while. She updated the dietician monthly and R8 did not have any weight loss the last time the dietician was at the facility. She reported that she does review weights weekly and if she identified something she would report that to the director of nursing to address. She stated that the facility had tried boost supplement with R8 but she was unsure if he drinks the supplement or not as dietary does not provide that to him nursing does. Interview on 2/26/25 at 8:59 a.m., with director of nursing (DON) identified that the dietician reviewed residents for weight loss. The dietician would assess and make recommendation, and nursing would communicate that with the provider. The dietician only comes once a month however, if there was a concern outside of that time frame, the facility can call her. Nursing can also make recommendations to the provider. Interview on 2/26/25 at 3:10 p.m., with registered nurse (RN)-B who confirmed that the provider had not been updated on R8's potential weight loss. She revealed that the dietary department had lacked communication about his weight loss and the facility needed to improve their communication during their interdisciplinary meetings (IDT). RN-B reviewed R8's weights and agreed that according to the charting R8 had lost about 30 pounds over last 6 months. RN-B confirmed that the discrepancy should have been investigated as there could have been multiple variables. The dietary manager should be monitoring weights and reporting to nursing who then should have notified the provider. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/3/25 at 4:57 p.m., with registered dietician (RD) identified she would expect to be notified if there was a resident identified with weight loss so that she could assess the resident. She revealed that the dietary manager provides her with a list of residents that need to be assessed, or that were new admission, and/or had an annual assessment due. She was unaware R8 had a weight loss and would expect that she should be able to trust that the dietary manager to be monitoring weights and would notify her with concerns. The interdisciplinary team (IDT) should be discussing concerns like weight loss at their meetings and nursing also should have notified the provider. She reported it was frustrating that it seemed like no one was addressing issues when they came up like this. She further revealed the problem that she had at times was with the contracted staff who do not seem to know the residents or just blow you off when you ask about a resident. She was told they are contracted pool staff, and they do not know. She would have expected when the discrepancy was identified in the facilities electronic record, point click care (PCC) that someone would have re-weighed the resident and investigated to see if a different scale had been used or some other variable had taken place. She confirmed that PCC does flag discrepancies with weights within the system to alert staff and at that time should have been addressed. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation for a resident with a significant weight loss to be assessed by the dietician or nursing staff to determine the cause of the weight loss, notify the primary provider and implement appropriate interventions as needed. Review of 1/20/22, Weight Assessment and Intervention policy identified any weight change of 5% or more since last weight assessment the staff would re-weigh resident and if weight was verified the nursing staff would immediately notify the dietician. The dietician would then respond within 24 hours of notification. An assessment would be completed with the physician reviewing medication that could be causing the weight loss, care plan would be reviewed and revised as need with interventions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 39988 Based on observation, interview and document review, the facility failed to consistently monitor and assess a resident for potential complications related to dialysis treatment post treatment for 2 of 2 resident (R18 and R42) reviewed for dialysis. Findings include: R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. Observation on 2/25/25 at 7:45 a.m., R18 showed a dialysis port in her right upper chest. R18 2/27/25, Order Summary Report identified R18 was on a renal diet and consistent carbohydrate diet. The order summary had no mention of monitoring access site for signs and symptoms of infection, no mention of location of access site, and no mention of dialysis schedule. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 would have interventions should she have any signs of complications from dialysis occur through the review date. Staff were to encourage her to attend dialysis. Staff to monitor her intake. Staff to monitor and report sign or symptoms of infection to her access site. Staff were not to draw blood or take a blood pressure in arm with graft. The care plan lacked identification and location of her access sight to be monitored. The care plan lacked identification of dialysis schedule or where R18 attended dialysis at. Review of R18's pre/post dialysis evaluation assessments identified that the assessment had been completed in January 2 out of the 4 times and in February 4 out of 10 times reviewed. R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. Interview on 2/26/25 at 3:10 p.m., with registered nurse (RN)-B confirmed that R18 had not consistently had a pre/post dialysis assessment completed since admission. She further confirmed that R18's dialysis access was not identified on her treatment record nor her care plan. She revealed she had a right chest port and a right arm fistula and without identification of the access location the nurse would not know where to look especially the contracted staff. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident on dialysis should have their access site assessed at a minimum upon returning from dialysis each time. Review of 6/19/19, dialysis agreement identified the nursing facility was responsible for transportation, contacting the dialysis unit and/or nephrologist for dialysis related problems. Assessing the dialysis resident including access observation, vitals and weight if needed. Review of 11/3/21, Dialysis Care External Facility policy identified the nursing staff would observe the residents access site upon return from the dialysis treatment for bleeding and/or other complications.

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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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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687 Based on interview and document review, the facility failed to notify the medical director for 1 of 1 resident (R41) who exhibited increased and ongoing behaviors since shortly after admission, with no mental health intervention to receive appropriate treatment and services and had questionable mental ability to refuse cares and treatment. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's current, undated physician orders identified R41 had 9 medication orders listed to included higher risk medications such as Apixaban (blood clot prevention medication), mirtazapine (antidepressant), and amlodipine (high blood pressure medication). R41's current, undated care plan identified R41 was noted to be independent with all Activities of Daily Living (ADL), and could transfer and perform personal cares independently. Staff noted in the Behavior Management focus the goals was for undesirable behaviors to be monitored and managed. Staff were to: 1) Attempt an alternate time to provide care if refused. 2) Educate R41 and his family (FM)-A of the necessity of care. 3) Ensure the safety of R41 and others. 4) Monitor for emotional factors that may contribute to new behaviors. No other interventions were noted or documented related to how staff were to provide appropriate care to R41 with repeated refusals of medication and care. R41's progress notes identified on: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating my father , my father, my father takes care of me. My father tells me what to do and he says no touch. R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because God told him to. Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would need to go to behavioral health again. The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. 3) 9/16/25 at 2:09 p.m., a call was placed to the primary care physician (PCP) nurse regarding R41's worsening and refusals of cares, medications, and meals. R41 had not allowed staff to touch him. R41 advised staff he was fasting for the entire month of September 2024. Staff expressed their concerns and asked for orders and suggestion. R41's PCP faxed back an order for staff to administer Haldol intramuscularly (IM) 5 milligrams (mg) every 4 hours x 2 doses. If no improvement, the order directed staff to send R41 to behavioral health again. R41's family member (FM)-A was called and stated to staff there was nothing they could do if he wouldn't take his medications .he would have to go back to the behavioral unit. FM-A gave permission for staff to administer the medication. 4) 9/16/24 at 2:47 p.m., staff attempted to enter R41 to speak with him about fasting. R41 began to scream at staff to get out of his room. The nurse attempted to educate R41 on the need for the injection and began screaming AHHHHHHHHHH NO injection!. R41 told staff he would not eat and is fasting for the month. He refused to allow staff to assess him and told staff to get out. The IM Haldol was given. 5) 9/17/24 at 10:12 a.m., staff noted R41 was in his room seated in his recliner. Staff offered food. R41 replied his food was poisoned. When staff attempted to interact with him, he raised his voice and told them not to touch him. He was upset staff gave him 2 injections (the previous day). The nurse tried to reiterate why R41 received the injections due to his delusions. R41 repeated more delusions such as I have intel. Another call was placed to R41's PCP. The PCP advised staff to proceed with a transfer to behavioral health. 6) 9/16/24 at 5:24 p.m., a call was placed for a non-emergent ambulance. EMS staff asked R41 questions and reported NO, I am normal .go away!. EMS identified R41 knew his name, and his location and had refused transfer. EMS told staff due to his ability to answer those questions, They were unable to take R41 to behavioral health as he was oriented correctly. EMS left without the resident due to his refusal for transfer. R41's PCP was updated. Numerous notes were made after 9/16/24, related to R41's ongoing refusal of all cares. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7) 10/1/24 at 10:47 a.m., staff noted they had called FM-A about R41's refusals of medication. Staff suggested discontinuing all medication as they felt it caused more behaviors. FM-A said lets do it. There was no indication staff had first checked with R41's PCP, behavioral health, or the medical director at that time on how they could best provide care and services to R41 prior to requesting family approval to discontinue medication. 8) 10/21/24, R41 was seen in house by contracted behavioral health services. A fax back after the visit was received with orders to administer Abilify (antipsychotic medication) IM and continue to try and give oral medications as he allowed. They also received a new order for as needed lorazepam (anti-anxiety medication) IM for agitation and severe anxiety and follow up every 14 days. Staff were instructed to contact the clinic with any concerns. 9) 10/21/24 at 11:25 p.m., a note was placed identifying R41 was seen in house by his PCP. No new orders were given. R41 refuses to take all medication. R41 was noted to be in his room all day and getting up only to use his bathroom. Staff noted no delusional behaviors. 10) 10/22/25 at 9:15 p.m., staff noted they had received electronically signed progress notes form the PCP. Staff noted they were unable to assess R41 or obtain vital signs. Per the PCP, they will return in 2 months to recheck. Further review of the progress notes repeated the same inability of staff to provide care and services to R41. Review of a R41's physician progress notes identified on: 1) 10/22/24, the PCP noted diagnoses of agitation, depression, catatonia (group of symptoms that usually involve a lack of movement and communication, and can include agitation, confusion, and restlessness), chronic anemia (low iron), high blood pressure, liver disease, enlarged prostrate, mild persistent asthma, high cholesterol, and chronic obstructive pulmonary disease (COPD). R41's PCP noted he was followed by psychiatry. R41 refused everything including vital signs, examination and appeared to be quiet in his recliner. He was apparently in no pain but again refused to be touched or examined. The PCP noted it was a difficult assessment because patient refused talking to us and refused to be examined. The PCP directed staff to continue with his blood pressure medication (Amlodipine) if he accepted. Depression with catatonia, and combative behavior were identified with orders directing staff to continue Haldol every 6 hours as needed. No end date was given. Staff were instructed to give his lorazepam at bedtime, mirtazapine and Abilify (anti-depressant) and continue with escitalopram (another anti-depressant) and continue with his inhaler related to COPD as tolerated and accepted by R41. The PCP noted R41 was a difficult patient to take care of as he consistently refuses care .will return in 2 months to recheck should he allow us to examine him and check vitals. 2) The nurse practitioner (NP) documented R41 was refusing all cares. Will continue current medications as patient allows (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's 6/3/24, inpatient psych note from the Behavioral Health Hospital (BHH) identified R41 had diagnoses of catatonia, major neurocognitive disorder, altered mental status, and hypoxemia (lack of oxygen to the brain). R41 was identified to bat continued high risk/complexity secondary to the combination of acute on chronic psychiatric diagnoses, cormorbid medical illness, and use of multiple psychotropic medication. R41 had received electroconvulsive therapy (shock therapy) as an inpatient at the hospital. R41 had improvement there both physically and mentally. He was no longer catatonic after treatments with ECT and medication management. At that time, R1 was noted to be cooperative, well groomed and well nourished. R41 had no delusions, hallucinations, or paranoia with insight fair and improving. Upon his admission, R41 was an unreliable historian, had limited judgement in decision making in every day activities, social situations, and compliance for treatment. R41 had a previous BHH stay in April 2024, due to sever deterioration in functioning and concerns for catatonia. R41 failed to have the capacity to consent for decision making upon admission due to his mental health exacerbation. R41's behavior history task, documented by staff identified staff had checked R41 exhibited no behaviors of any kind. R41's September 2024 through February 2025 vital signs report identified vitals were obtained on 9/9/24. Of those vitals, R41 had 1 weight measurement on 9/9/24 of 191 lbs. No other weights were documented as obtained. R41 BP on 9/9/24 was listed at 168/101 mm/hg and his oxygen saturation (SpO2) was documented as 93%. On 2/25/25, the same date as the MDS note listed above, R41's BP and SpO2 readings were documented as the exact same as September 2024. No other vitals were obtained for R41 throughout his stay from September 2024 through March 2025. R41's bathing history was reviewed for the previous 30 days prior to the survey. At no time during February was R41 bathed. R41's assessment data history from September 2024 through March 2025 was obtained. R41 had only 3 assessments noted as completed. Those assessments were a [NAME] pressure ulcer risk assessment. One upon admission, one at R41's 11/21/24 quarterly assessment, and then R41's currently in progress 2/19/25, MDS assessment. No other assessments were documented for R41 from September 2024 through March 2025. R41's personal hygiene task for the last 30 days prior to survey was viewed. R41 was noted by staff to be completely independent with personal hygiene. It is unclear how staff determined this to be accurate and true. R41's March 2025. Medication and Treatment records (MAR/TAR) identified R41 had not received medications or treatments. Corresponding progress notes made by nursing staff in the medical record identified R41 refused all medications and cares. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/03/25 at 4:26 p.m., with RN-A identified she was familiar with R41 and had even cared for him at the sister facility before it closed. RN-A stated R41 refuses everything. There are very limited staff who can interact with R41. He strikes out, kicks, and has verbal behaviors. R41 will not leave his room. She thinks R41 is continent or bowel and bladder, but acknowledged without being able to assess R41, there would be no way to know. Staff provide no cares or treatments for R41. RN-A was unaware if he even allowed linens to be changed on his bed or his clothing washed. RN-A had not seen R41's skin since he was administered Haldol in September 2024. RN-A was unaware staff were documenting R41 as having no behaviors, however, she related that to not being allowed to enter R41's room or provide any cares. RN-A recalled she has been unable to perform any assessments, give medication, or provide cares to R41 since September 2024. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified she was aware R41 refused all cares, assessments, or treatments. When asked how staff can accurately and comprehensively assess R41, she noted they cannot. She agreed staff are providing no skilled nursing related to R41's refusals. The DON agreed the medical director should have been notified to assist with R41 when he was not able to make safe decisions regarding his care. Interview on 3/4/25 at 8:16 a.m., with the medical director (MD)-A identified he was unaware of R41's refusal of all cares. He would expect to be notified as he agreed R41 isn't capable of making an informed decision related to his health and safety. He was unaware R41 received no skilled nursing care, had only 2 baths since admission, refused all meds, and had no laundry done. He was also unaware staff were unable to comprehensively assess R41. He agreed the assessment data included on the MDS would be false if staff could not actually assess R41. Review of the 10/18/21 Behavioral Health Services (BHS) policy identified BHS were to be provided as part of the interdisciplinary, person centered approach to care. Staff were to promote dignity, autonomy, privacy, socialization and safety as appropriate and were to be trained in ways to support residents. Staff were to be trained in protocols and guidelines related to mental disorders and psychosocial adjustment difficulties of residents. There was no mention what professional references staff were to use to guide decisions on what to do if current interventions were not working to ensure the health and safety of resident with poor decision making capabilities was maintained.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39988 Based on observation, interview and document review the facility failed to ensure controlled medications were reconciled according to the facility protocol to prevent potential diversion for 1 of 1 emergency kits reviewed. Findings include: Observation and interview on 3/3/25 at 3:36 p.m., with registered nurse (RN)-C of the medication room on first floor. Observed was a refrigerator with a paddle lock on it with the key being on the nurse's key ring. Located inside the refrigerator was a clear box with 2 vials of Lorazepam 2 milligrams/milliliter (MG/ML) an antianxiety medication and a red plastic tag with the number 0501539. RN-C reported that the Lorazepam was from the emergency kit and counted each shift. The count was documented in the narcotic log located on the medication cart. Review of the narcotic logbook with RN-C found he was unable to find that the Lorazepam had been reconciled and documented. RN-C revealed that at shift change they had not checked the emergency Lorazepam from the refrigerator. RN-C confirmed that the nurses should be confirming the red plastic tag number on the box with the emergency Lorazepam each shift to monitor for diversion. Review of the emergency kit medication list identified Lorazepam 2mg/ml quantity of 2 vials. Interview on 3/3/25 at 3:45 p.m., with licensed practical nurse (LPN)-A confirmed that the emergency Lorazepam located in the refrigerator had not been getting reconciled. LPN-A agreed that the Lorazepam red tag number and amount should be monitored at each shift change. Interview on 3/3/25 at 3:50 p.m., with director of nursing (DON) confirmed that the emergency Lorazepam should be monitored each shift and that the nursing staff should be documenting the red tag number and verifying the amount to monitor for diversion. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that the nursing staff would monitor controlled medication to avoid the risk of medication diversion. Review of 3/3/25, Controlled Substances policy identified that the facility would reconcile controlled medication upon receipt, administration, disposition, and at the end of each shift. The nurse coming on duty and the nurse going off duty would reconcile the count together. Discrepancies in controlled medications would be documented and reported to the director of nursing. Investigations in all discrepancies of controlled medication would be completed. The discrepancies would be reviewed with the pharmacist and administrator to determine further action if needed. The director of nursing would periodically review policies and procedures for monitoring controlled medication to prevent diversion.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 39988 Based on interview, and document review the facility failed to ensure 1 of 1 resident (R18) received ordered therapeutic diet to maintain or improve their nutritional status. Findings include: R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. Review of the 5/14/24, Centers for Disease Control (CDC), Diabetes and Kidney Disease: What to Eat?: article located at, https://www.cdc.gov/diabetes/healthy-eating/diabetes-and-kidney-disease-food.html, identified, A healthy diabetes diet looks pretty much like a healthy diet for anyone. Eat lots of fruits, veggies, healthy fats, and lean protein. Eat less salt, sugar, and foods high in refined carbs. With a chronic kidney disease (CKD) diet, you'll avoid or limit certain foods to protect your kidneys. You'll include other foods to give you energy and keep you nourished. Your specific diet will depend on whether you're in early-stage or late-stage CKD or if you're on dialysis. Depending on your kidney disease stage, you may also need to reduce the potassium, phosphorus, and protein in your diet. Many foods that are part of a typical healthy diet may not be right for a CKD diet. Your nutrition needs will change with late-stage CKD. If you're on dialysis, you may need to eat more, especially more protein. Your appetite can change because food tastes different. R18's 1/23/25, hospital discharge orders identified renal consistent carbohydrate diet. R18's 2/27/25, Order Summary Report identified R18 was on a renal diet and consistent carbohydrate diet. Review of R18's diet slip from the dietary department identified diet as diabetic. There was no mention of foods to avoid or special instruction on the diet slip. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 had no mention of nutritional status and diet to be provided. Interview on 2/26/25 at 3:46 p.m., with dietary aide (DA)-A who reported she was unaware of what a renal diet consisted of but could ask the cook if she knew. Interview on 2/26/25 at 4:23 p.m., with nursing assistant (NA)-A who reported R18 was on no restrictions, and she did not care for the food offered to her, so her daughter brought her food in frequently. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/27/25 at 9:20 a.m., with registered nurse (RN)-D who reported R18's orders identified R18 was on a renal diet and consistent carbohydrate diet. Interview 2/27/25 at 9:28 a.m., with cook (C)-B who identified R18 was on a diabetic diet and not on a renal diet. The kitchen did not give her anything special for a diet, she was served the same foods as everyone else but in smaller portions. . Interview on 2/27/25 at 12:21 p.m., with dietary manager identified upon admission she was given a diet slip for a diabetic diet for R18. She confirmed she knew R18 attended dialysis, so she received smaller portions. R18 was to also avoid potassium. R18 basically received the same diet as everyone else but smaller portions. R18 had no fluid restrictions, and her labs were followed by the hospital dietician. Interview on 3/3/25 at 12:14 p.m., with C-B who reported she served R18 fried chicken, mashed potatoes, and sherbet for lunch. She revealed she sent the tray up to first floor between 11:45 and 12:00 noon. R18 received smaller portion sizes verse the regular size meal as she was on a diabetic diet. Interview on 3/3/25 at 12:18 p.m., with licensed practical nurse (LPN)-A identified R18 left at 11:30 a.m., for dialysis. LPN-A reported that R18's daughter brought R18 food frequently. No dietary tray was sent up for R18 because the kitchen does not send meal trays to R18 on dialysis days as her daughter will bring her food. LPN-A was unsure how staff documented meal intakes when her daughter brings her food. Interview on 3/3/25 at 1:51 p.m., with dietary manager identified nursing communicates diet orders by filling out a diet slip. R18's daughter brings her food in frequently as R18 wants more tradition foods related to her culture. The dietary department does not send a meal tray to R18 if they know that the daughter brought her in food. Interview on 3/3/25 at 2:00 p.m., with RN-D identified a copy of the diet order upon admission was given to the dietary department and a dietary slip was filled out with the diet order. If there was a new dietary order from dialysis nursing would give a copy of that order to the dietary department and fill out the dietary slip. Interview on 3/3/25 at 4:57 p.m., with registered dietician (RD) identified the dietary department should be knowledgeable about a renal diet. R18 should be on a renal diet and receive limited potatoes, and potassium rich food. R18 should be served a meal tray regardless of the daughter bringing in food for her. R18 can decline to eat the meal but should be offered the meal. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that dietary department would provide the appropriate prescribed diet as ordered. A copy of the original physician diet order was request but not provided. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated Diet and Nutrition Care Manual for Renal Dialysis identified carbohydrates should be controlled if needed in residents with hyper or hypo glycemia, sodium should be restricted if needed to avoid excessive fluid retention, fluid intake was individualized, potassium should be adjusted to maintain a potassium level within normal range. Phosphorus should be adjusted to maintain phosphate levels in the normal range.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47497 Based on observation, interview, and document review, the facility failed to ensure the ice machine, kitchen and food prep areas were kept clean and sanitary. This has the ability to affect all 56 residents. Findings include: Observation and interview on 2/25/25 at 7:15 a.m., during the initial kitchen tour a stainless-steel food prep counter across from the stove had a lower shelf directly below. The lower shelf was used to store cutting boards, oatmeal, oil, cooking spray, and small cups used for serving condiments. The shelf had a dry black/brown substance on it and a brown liquid substance covering a large area of the shelf. In addition, approximately the first 3-5 inches from the edge of the shelf nearest to the stove and covering the full length of the shelf had a greasy, sticky build-up. The area had dirt and grime stuck to the greasy area. The shelf had a plastic container containing condiment cups, the container was visibly dirty with unknown brown substance. Food crumbs could be seen laying in the bottom of the container. On 2/25/25 at 4:45 p.m., during a follow up observation of the kitchen, identified cook-C was sitting on the freezer using her cellular phone. Interview on 2/25/25 at 4:45 p.m., with cook-C agreed with the above finding and identified they were not supposed to be sitting on the freezer as this area was at times used to set food on, in addition she identified they were not supposed to use their cell phones in the kitchen as this could be a source of cross contamination. Interview on 2/26/25, at 10:28 a.m., with the dietary manager (DM), she agreed with the concerns regarding the cleanliness of the kitchen, she identified that staff are signing off that they completed the cleaning, she reported that she may need to do some re-training with staff and she may have to be more specific on her cleaning logs as to what staff are expected to clean. Interview on 3/3/25 at 4:45 p.m., with the registered dietitian (RD), identified she would expect staff to only use their cell phone while on break and in the staff break room. Personal items such as cell phones should be left in a locker and not brought into the kitchen. She identified this practice could potentially cause cross contamination with food. In addition, she would not expect staff to use the chest freezer as a seating area. She identified that she has not completed any visual audits of the kitchen and was not aware of the lack of cleanliness. She would expect the dietary manager to be auditing regularly and ensuring the daily cleaning is completed properly. Observation on 2/26/25, at 8:40 a.m., of the ice machine located in a hallway connecting the main building with a house where offices were located. The ice machine had a white crusty buildup (like mineral deposits) visible from the outside of the machine located between the plastic hinged lid/door and the machine. inside the door at the top of the opening just above the ice bin, a strip of metal had a black/gray/brown spotty build up going all the way across. Some of the buildup was removable with a dry paper towel and friction rubbing the area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 2/25/25 at 8:40 a.m., with the Maintenance director identified he had been working in the building since last fall when they closed the other facility. He reported he does not keep a log of when he cleans and de-scales the ice machine, when it comes up in tells I clean it. He cleans it about every 6 months and does a deep clean about once a year. He reported it had been de-scaled last August of 2024 and cleaned a little before thanksgiving. Review of the Manitowok Indigo Ice Machine Manufacturer Installation, Use, and Care Manual identified the ice machine should be cleaned and sanitized every 6 months. Review of the General Sanitation of Kitchen policy identified the kitchen cleaning schedule with be outlined in writing, tasks will be assigned to the responsibility of a specific position, frequency of cleaning for each task will be defined. Employees will initial, and date when the task was completed.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38687 Based on interview and document review, 1 of 1 Governing Body failed to provied appropriate oversight to ensure deficient practice had been corrected and coompliance achieved. Refer to F636, F656, F684, F758, F812, F842, F865, F880, F882, and F944. Findings include: Review of the QAPI meeting minute attendance from the 3/25/25 QAPI Meeting (meetings are held monthly) identified attendees present were the administrator, the director of nursing (DON) the assistant director of nursing (ADON), the infection preventionist (IP) the social services designee (SSD) and the pharmacist. The medical director was absent for this meeting. During the meeting, topics discussed were as follows: 1) Pressure Ulcers: There were 14 active pressure ulcers involving 5 residents. The facility goal was to have 5% pressure ulcer rate. Current facility percentage was left blank. After discussion, actions present were the facility was working on care plans and turning and repositioning, working on healing wounds. There was no measurable action or presentation of evaluation of the data to define commonalities such as where pressure ulcers were located on residents, possible causes, co-morbidities, areas for improvement, or potential education to staff or audits that should occur in order to achieve compliance. 2) Falls: There were a total of 16 falls in February. 2 documented minor injuries. There was no goal or current facility percentage listed. Actions identified were staff reviewed all care plans (CP) causative factors were reviewed. Isolation was a top contributor; however possible urinary tract infections (UTI) were noted as well. Staff were still looking at R1 t see if she could be care planned to safe transfers from bed in the lowest position as it seemed to be when she had been found on the floor. It was not plausible at that time. No other factors were identified or discussed such as time of day, residents requiring increased supervision, staff competence with transfers etc. 3) Infection control and antibiotic stewardship: There was no facility goal or current benchmark listed. There were 39 active cases of infection the previous month with 22 respiratory (26 new) with COVID, pneumonia, and RSV identified. 4 UTI, 1 case of bone infection, and 2 others noted but not identified. Actions taken were to continue isolation and testing and keeping residents on droplet precautions. It was noted they were working on getting the IP classes in infection control and surveillance, working on appropriate personal protective equipment (PPE) audits and handwashing. It was noted to continue for the foreseeable future There was no indication it had been discussed how the facility was to ensure the IP had received time to complete her training, who was in charge of oversight until that occurred, or how the facility was to achieve their goal or what education may be needed or evaluation of actions already in progress. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	4) Plan of correction (deficiencies from the previous survey): Auditing for compliance with previous deficient practice had begun. Another area identified was regarding psychotropic diagnosis. Actions identified QAPI was to create/locate resources for training that could be implemented within the organizational structure. A few residents need to have their diagnoses reviewed and updated to ensure they had the appropriate diagnoses. There was no indication to identify any goals, or plans of action noted as to how the facility was going to achieve compliance, who was designated to oversee compliance of certain areas, or how they would achieve compliance noted as discussed. 5) Open positions: There were 20 positions open. There was no facility goal or current status noted, nor was there any discussion of how QAPI would work toward filling positions. There was also no mention of how staff shortages were affecting care at the facility, if staffing was being maintained according to positions noted to be required in the facility assessment in order to care for residents, or if the shortages had affected other areas such as the high number of pressure ulcers or resident falls etc 6) Grievances/Abuse reporting: 2 grievances were noted for call light response, 3 involving cares, 1 for environment, and 1 for diet. Actions noted were: a) A call light audit was run, and education was to continue with staff. Audits showed an average of a 10-minute response time, however, there was no indication staff had observed call lights to ensure the electronic data was accurate and staff were not simply shutting off the light. 1 family reported the light was on for an extended time and made her worry that if it was related to something serious, the resident could have a poor outcome. There was no indication what was an acceptable call light wait time was, how long or what the results identified were, or it the long wait times could have been a result of a lack of staff availability. b) Cares: A family felt care wasn't being provided to their standards. The care plan was changed to reflect requests. 1 resident felt staff treated her differently as she must wait longer for care. A meeting was held with family and the county case worker. Another family had voiced concerns over staff knowledge. c) Diets: A resident continued to be served food that are listed as foods she can't have. Staff had been educated and signed an understanding of the food identified. There was no indication QAPI identified competencies may be warranted if this was an ongoing issue. d) Antipsychotic Use: The facility goal was to have no more than 15%. there was no indication on what the present percentage was. Discussion: there was roughly 21% of antipsychotic medications used in the facility. Information was presented to the assistant DON (ADON) by the pharmacist (RPh). The notes included the last gradual dose reduction (GDR) and when drugs had been started. This was noted to help the MDS and keeping things more organized. There was no indication staff had reviewed deficiency related information regarding to correct diagnoses or if the pharmacist had reviewed all residents affected as part of his contractual service. e) Other areas: were noted in QAPI for Adverse events, resident immunizations, abuse allegations etc. Those areas also lacked thorough analysis of data. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	f) Emergency Meeting: Discussion was left blank. Action identified were each tag cited for the recertification survey previous to this survey. Audits were noted to be going forward from that point on to identify deficient practice. No staff were designated to make sure actions identified by the facility had been completed, residents identified or found to be at risk reviewed etc. QAPI identified the QAPI program deficiency cited needed to be more cognizant about documentation that reflects accuracy; however, no plan had been placed to ensure its completion by 4/3/25 (the completion date listed on the plan of correction) would occur. Interview and document review on 4/8/25 at 1:02 p.m., with the administrator identified he indicated the QAPI committee met to discuss the results of their previous survey. He had not provided oversight himself, as the regional nurse consultant was responsible to write the POC and determine what steps were necessary to ensure compliance. He noted the facility had such a short window to get deficient practice corrected. He was unaware the DON and ADON had not ensured the IP had time to complete her education to be able to oversee the infection control (IC) program independently, nor was he aware the DON and ADON were not providing direct oversight of the program until the IP was trained and deemed competent. The administrator also agreed he was ultimately responsible to ensure staff such as the director of nursing (DON), had provided the appropriate oversight to ensure all items identified in their POC were implemented to correct the deficient practice. The facility had educated staff to the policies, but agreed meaningful education and competencies to check staff had understood the education and applied it correctly had not occurred. He also had not ensured staff were educated to what the facility's specific QAPI plans, and monitoring was, nor had he ensured they were educated to the QAPI 's new PIP programs. He identified the facility was planning to change how they did QAPI to ensure they could be compliant with analyzing data, and providing oversight of any deficient practice, education, etc., but that had not occurred yet. Review of the 1/29/25, QAPI Policy identified the facility was to maintain a QAPI committee for continuous quality improvement and overall performance. One of QAPI's objectives was to establish and implement plans to correct deficiencies, and to monitor the effects of these actions plans on resident outcome. The governing body shall be ultimately responsible for the QAPI program.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 49336 Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. This has the ability to affect all 56 residents. Findings include: Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to review, identify and determine appropriate interventions and oversight of outcomes brought forth Interview on 3/04/25 at 2:26 p.m., with administrator identified the merge of two nursing homes, that included residents and staff, added an extra layer of challenges the facility was currently navigating. He identified updates of the facility assessment, had not yet been implemented, including staff education. However, He identified there was decisions made in relation to resident cares, resources and services that were to relay to all staff the facility's operational goals and performance improvement projects (PIP). Review of August 2024 Facility Assessment Tool identified the leadership team would discuss goals to ensure direct care staff are trained to provide services to residents. The facility identified staff education, training, certifications, testing, and facility policies to support the care needed for the residents. In addition, the facility would gather input from residents, family members and staff of concerns and expectations that would meet residents needs through regulatory, operational, maintenance and staff training requirements. Lastly, the facility would review resources annually, and would evaluate day to day operations, including emergencies, to identify and act on opportunities for improvement and to ensure residents care maintain their highest practicable physical, mental and psychosocial well-being.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39988 Based on interview and document review the facility failed to include the run/communication report from dialysis in the facility medical record for 2 of 2 residents (R18 and R42) reviewed for dialysis, in addition the facility failed to transcribe physician order for 1 of 1 resident (R44) following an appointment. Findings include: R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. Staff were to encourage her to attend dialysis. The care plan lacked identification of dialysis schedule or where R18 attended dialysis. R18's electronic medical record, point click care (PCC) identified R18 had 2 copies of her dialysis run/communication report. One report was dated 1/24/25 and the second report was dated 1/27/25. The facility electronic medical lacked all other dialysis run/communication reports from dialysis. R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. R42's electronic medical record PCC identified the last dialysis run/communication report was from 1/27/25 with no further reports in R42's facility medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/3/25 at 11:24 a.m., with registered nurse (RN)-B identified contracted licensed nurses working at the facility were unable to access hospital medical records. We used to have a medical records person, that could obtain and add records from the hospital to the facility medical record, but we no longer have the position. Review of 6/19/19, Dialysis Agreement identified communication would be shared between dialysis and the nursing home regarding the run summary, any related dialysis complications, new orders, and any changes in condition or concerns related to the vascular access site. Review of 11/3/21, Dialysis Care External Facility policy identified shared communication between the dialysis center and the nursing home would be coordinated by the director of nursing or designee. The communication would include post weight, blood pressure and dialysis site condition. Nutritional management will be coordinated between the dialysis dietitian and the facility dietician with recommendation initiated when received. 47497 R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased swelling to her lower legs. The physician placed orders to add a water pill to decrease fluid in legs, and for staff to wrap her legs or put compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse, and she identified she was not aware of the new orders but would check into it. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. R44's March 2025 medication administration record identified an order to apply ace wraps to bilateral lower extremities daily. The order entry date was 2/27/25, the order had been transcribed 8 days after it was received from the physician. Furosemide oral tablet 20 mg twice daily in addition to 20 mg for a total of 40 mg twice daily for 30 days transcribed on 2/21/25, 2 days after the order was received. R44's medication/treatment administration record lacked any direction for nursing staff to elevate lower extremities or to apply antifungal powder under abdominal folds. Interview on 3/3/25, at 11:15 a.m., with RN-B and RN-D, identified their process is to review the new order upon receiving, transcribe the order, make a nursing progress note, and place the original copy in a wall pocket behind the nurse's station for the medical records person to scan into the medical record. They identified the orders received following R44's 2/19/25 appointment had been transcribed late and the original order was not yet scanned into the medical record. RN-B reported they did not currently have a medical record person, and she was told they had planned to resolve that position, she stated nursing does not have time to scan all the orders in, she further revealed that they only complete a second check on narcotic orders and admission orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent interview on 3/3/25, at 11:58 a.m., RN-B came to the conference room with the original order. She reported she found the order in a pile of papers that were waiting to be scanned in. R44's 2/19/25, original physician order identified staff were to apply antifungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. Interview on 3/4/25 at 8:15 a.m., with the facility medical director identified he would expect facility staff to transcribe and implement physician orders upon receipt. A facility policy for order transcription was requested but nothing was provided by the end of the survey period.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49336 Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 56 residents. Findings include: Review QAPI minutes from February 2024 through January 2025, identified department heads were bringing data forth to QAPI on various topics such as infection control, falls, incident reports, vaccinations, etc. However, there was no documented benchmarks for goals the facility was trying to achieve, nor monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to review, identify and determine appropriate interventions and oversight of outcomes brought forth. Interview on 3/04/25 at 2:09 p.m., with administrator identified the merge of two nursing homes, that includes residents and staff, added an extra layer of challenges the facility was currently navigating. He identified there was no measurable goals set, or if goals were met to improve areas identified in QAPI. He and the QAPI committee would need to formalize a process to identify improvements that would reflect changes as needed in QAPI. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources and services.

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 03/04/2025
NAME OF PROVIDER OR SUPPLIER The Shores of Worthington		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49336 Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement an action plan to correct the identified concerns or to ensure the committee participated in the development and oversight of implementation of systems, and to ensure quality of life and quality of care were maintained for 57 residents residing in the facility. Findings include: Review of QAPI minutes from February 2024 to January 2025, identified on 4/19/24 the facility was to implement a performance improvement project (PIP) of abuse allegations. There was no mention on how the facility would meet goals, monitor progress or evaluate current measures to ensure compliance. Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to review, identify and determine appropriate interventions and oversight of outcomes brought forth. Interview on 3/04/25 at 2:26 p.m., with administrator identified the merge of two nursing homes, that includes residents and staff, added an extra layer of challenges the facility was currently navigating. He identified there were challenges and improvements related to resident cares, resources and services to be streamlined and identified in QAPI. He identified the facility had no performance improvement projects in place at this time. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources and services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38687 Based off document and interview, the facility failed to ensure 1 of 1 resident (R41) with a highly infectious disease (Hepatitis C) was placed into the infection control (IC) surveillance data for monitoring. In addition, the facility failed to ensure oversight of the IC program was maintained for tracking, trending, and analysis of data to prevent potential spread of infection. The facility also failed to include staff return to work information in surveillance to identify if they were appropriately vetted before their return for 1 of 3 months (January 2025) reviewed. This has the potential to affect all 56 residents. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C. R41's current, undated care plan identified there was also no mention of his Hepatitis C diagnosis. Review of the surveillance for February and March identified infections were getting logged into the tracking system in the facility electronic medical records system (Point Click Care (PCC) by facility staff. R41 was not listed as being included in surveillance for his diagnosis of Hepatitis C. Review of the facility's previous revisit directed plan of correction for a deficiency cited in January 2025 identified the facility was to have contracted with a contracted infection preventionist (CIP). The contract began 2/17/25, The CIP was to have begun working immediately with the facility in assisting with the root cause analysis of the program related to the deficient practice, review the program as a whole, review the plan of correction, and support the facility in developing audit tools. Interview on 3/3/25 at 11:00 a.m., with the administrator identified the infection preventionist was out on medical leave and registered nurse (RN)-B was to oversee the program in her absence. Interview on 3/3/25 at 2:15 p.m., with RN-B identified she was never told to assist in oversight of the IC program. She had no knowledge of what was being inputted into the PCC program for tracking infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the employee line listings for December 2024 through February 2025 identified in January, 2025, there were 3 staff illnesses reported. The symptoms resolved category and the return to work column were left blank. Illnesses recorded were coughs, fever, and abdominal pain. During follow-up email correspondence with the director of nursing (DON) on 3/4/25, The DON had to check with payroll for 2 staff, however she was also listed as having been ill that month. She noted she had forgot to put in her return to work date into the IC surveillance. The DON agreed all data needed to be inputted to ensure illnesses were tracked and staff were kept off work for the appropriate amount of time. Interview on 3/03/25 at 5:37 p.m., with the DON identified the IP was off work beginning right after the State Agency revisit on 2/14/25. They had not had a meeting with a consultant until last week. The CIP had not yet reviewed or provided assistance with the IC program. The DON agreed R41's Hepatitis C was a highly infectious disease and should be on the surveillance. The facility had no one to cover IC during the IP continued absence. The facility had only first spoken to the hired consultant last week. They did not have a plan to cover the IP while on medical leave. Agreed IC needed appropriate oversight at all times to review data. Interview on 3/4/25 at 8:16 a.m. with the medical director (MD)-A identified he was unaware that facility had no active IP due to medical leave and no staff had replaced her. He agreed the IC program required direct oversight. He was also unaware the CIP was not advised of the facility's inability to designate an IP in IP-A's absence. R41's Hepatitis C should be included on the facility's surveillance as it is a highly infectious disease. There was no policy related to oversight of the IC program provided by the end of survey.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 38687 Based off document and interview, the facility failed to ensure oversight of the IC program was maintained to provide appropriate oversight for tracking, trending, and analysis of data to prevent potential spread of infection. This had the ability to affect all 56 residents. Based off document and interview, the facility failed to ensure 1 of 1 resident (R41) with a highly infectious disease (Hepatitis C) was placed into the infection control (IC) surveillance data for monitoring. In addition, the facility failed to ensure oversight of the IC program was maintained for tracking, trending, and analysis of data to prevent potential spread of infection. The facility also failed to include staff return to work information in surveillance to identify if they were appropriately vetted before their return for 1 of 3 months (January 2025) reviewed. This has the potential to affect all 56 residents. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C. R41's current, undated care plan identified there was also no mention of his Hepatitis C diagnosis. Review of the surveillance for February and March identified infections were getting logged into the tracking system in the facility electronic medical records system (Point Click Care (PCC) by facility staff. R41 was not listed as being included in surveillance for his diagnosis of Hepatitis C. Review of the facility's previous revisit directed plan of correction for a deficiency cited in January 2025 identified the facility was to have contracted with a contracted infection preventionist (CIP). The contract began 2/17/25, The CIP was to have begun working immediately with the facility in assisting with the root cause analysis of the program related to the deficient practice, review the program as a whole, review the plan of correction, and support the facility in developing audit tools. Interview on 3/3/25 at 11:00 a.m., with the administrator identified the infection preventionist was out on medical leave and registered nurse (RN)-B was to oversee the program in her absence. (continued on next page)

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	245596	A. Building B. Wing	03/04/2025

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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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 3/3/25 at 2:15 p.m., with RN-B identified she was never told to assist in oversight of the IC program. She had no knowledge of what was being inputted into the PCC program for tracking infections. Review of the employee line listings for December 2024 through February 2025 identified in January, 2025, there were 3 staff illnesses reported. The symptoms resolved category and the return to work column were left blank. Illnesses recorded were coughs, fever, and abdominal pain. During follow-up email correspondence with the director of nursing (DON) on 3/4/25, The DON had to check with payroll for 2 staff, however she was also listed as having been ill that month. She noted she had forgot to put in her return to work date into the IC surveillance. The DON agreed all data needed to be inputted to ensure illnesses were tracked and staff were kept off work for the appropriate amount of time. Interview on 3/03/25 at 5:37 p.m., with the DON identified the IP was off work beginning right after the State Agency revisit on 2/14/25. They had not had a meeting with a consultant until last week. The CIP had not yet reviewed or provided assistance with the IC program. The DON agreed R41's Hepatitis C was a highly infectious disease and should be on the surveillance. The facility had no one to cover IC during the IP continued absence. The facility had only first spoken to the hired consultant last week. They did not have a plan to cover the IP while on medical leave. Agreed IC needed appropriate oversight at all times to review data. Interview on 3/4/25 at 8:16 a.m. with the medical director (MD)-A identified he was unaware that facility had no active IP due to medical leave and no staff had replaced her. He agreed the IC program required direct oversight. He was also unaware the CIP was not advised of the facility's inability to designate an IP in IP-A's absence. R41's Hepatitis C should be included on the facility's surveillance as it is a highly infectious disease. There was no policy related to oversight of the IC program provided by the end of survey.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49336 Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility specific Quality Assurance Performance Improvement (QAPI) Program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. This had the ability to affect all 57 residents. Findings include: Interview on 3/03/25 at 2:58 p.m., with Registered nurse (RN)-B and RN-D identified the facility held scheduled meetings for residents and staff. Both RN-B and RN-D had not attended QAPI meetings and was not aware of any facility specific performance improvement projects. Interview on 3/03/25 at 3:04 p.m., with admission coordinator identified the facility plan was to prevent further infection control outbreaks related to COVID and respiratory syncytial virus (RSV). Interview on 3/03/25 at 3:09 p.m., with licensed practical nurse (LPN)-A identified she was not aware of QAPI meetings held and/or specific QAPI goals. Interview on 3/03/25 at 4:10 p.m., with RN-A identified she was aware the facility had monthly QAPI meetings and had not attended them. There were care areas and services the facility would need to address, but she could not identify any specific QAPI goals the facility had in place. Interview on 3/03/25 at 4:23 p.m., with nursing assistant (NA)-A identified she has attended QAPI meetings, in the past, if her schedule allowed, but was not aware of any QAPI goals the facility was monitoring. Review of email correspondence on 3/04/24 at 9:15 a.m., with director of nursing identified there was no formal education for employees of QAPI training. Interview on 3/04/25 at 2:09 p.m., with administrator identified the facility provided QAPI education to staff upon employment and would work towards formalizing QAPI requirements for all employees going forward. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources and services. Employee QAPI training was requested and not provided during survey.