STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. Building B. Wing	04/30/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation the facility failed to provide meals that were attractive and palatable during 1 of 1 observed meal service. Findings include: Observation on 4/28/26 at 11:30 a.m. until meal service was completed at 12:45 p.m. identified the menu for that meal was spaghetti with meat balls and sauce, garlic toast, and a lettuce salad. Additional food items prepared included mashed potatoes and gravy and canned pears. At 11:45 a.m., as cook-A began serving the meal for the lower-level dementia unit. The meal was plated, and the trays were loaded onto a cart which was pushed to the unit for serving. C-A used tongs to place spaghetti noodles onto the plates, and amounts of plated food to be served to residents were inconsistent with each plate. He then added a scoop of meatballs with sauce, a slice of toast and a bowl with lettuce topped with a small scoop of shredded cheese. A small plastic cup with diced pears was placed on the tray prior to being placed on the cart for delivery. Lettuce was identified as the vegetable served, and the only vegetable offered for those residents on altered texture diets, was mashed potatoes and gravy, (served with spaghetti). As the meal service progressed the noodles were becoming dried and gummy in appearance. C-A had to scrape the noodles from the bottom of the steam table pan to serve the final tray. In addition, the red plate covers had dried white residue on the surface, which the dietary manager identified as hard water residue. Silver ware was corroded with a dull grey appearance and spotted with white providing an old, soiled appearance. Bowls were light grey, and did not show the discoloration as easily, but white residue was visible on observation. Interview on 4/27/26 at 6:21 p.m. with R30 voiced concerns that food was overcooked, lacked flavor and there was no provision of seasonings to add to food served. She usually ate soup due to the condition of over cooked foods offered. She added, vegetables were not drained and were pooled in liquid when served and were cooked to the point of being mush, and fresh vegetables were not offered. R30 stated she chose to eat her meals in her room, and food was never hot when it was brought to her room. She reported concerns had also been voiced by other residents and discussed at resident council meetings. R30 reported she had purchased her own salad ingredients including bell peppers, onions, and tomatoes, which the kitchen did prepare for her, but only shredded lettuce was offered prior to her providing them. She further reported dishes and eating utensils were unappetizing due to heavy water spots and discoloration. The concerns had been voiced at food committee and resident council, but nothing had changed. Review of the 2/5/26, food committee minutes identified residents in attendance were R6, R15, R24, R28, R33 and R53. Staff in attendance included the dietary manager (DM), the activity director, and the activity aide. Discussion included water spotting on dishes and silverware, differences in preparation of menu items, menu likes and dislikes. There was no discussion concerning food temperature, palatability of food, consistent serving sizes, or availability of fresh fruits and vegetables. Review of the meeting minutes from 1/8/26, 11/6/25, and 10/1/25 followed the same format, but there was no discussion on the identified concern for palatability. Interview on 4/28/26 at 1:00 p.m. with the dietary manager (DM), who observed the final portion of the meal service, identified the noodles had become overcooked by the time the final trays were dished, and should not have been served. He further reported he had replaced bowls and cups recently, but hard water residue continued to be a problem, and he was hoping the facility would be able to do something about it. Interview on 4/28/26 at 5:50 p.m. the (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 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. Based on observation, interview and document review, the facility failed to appropriately maintain and clean 4 of 4 freezers in the facility kitchen. The facility also failed to ensure staff followed infection control practices when handling and preparing food and ensure food preparation equipment was allowed to dry prior to stacking and returning to the storage rack. This had the potential to affect all 49 residents in the facility. Findings include: Observation on 4/27/26 at 11:15 a.m. with the dietary manager (DM) of freezers utilized in the kitchen identified:An upright freezer used for storage of soups had food particles, and white residue on door hinges, shelves, and floor of the freezer. The handles were smudged and showed where the door edges had been griped with unclean hands, causing food like particles and soil to adhere to the surfaces. The surface of the door hinges had a buildup of soil, tan food particles, and white buildup that had accumulated. The freezer also had ice buildup on the shelves and walls of the freezer. A freezer used to store ice cream products, contained a package of opened undated French toast slices, and an open undated package of pancakes. The DM reported he did not know when the items had been opened or last used and removed the items stating they should have been sealed in a bag and dated when opened. The freezer contained food particles that had spilled on the floor and shelves of the freezer, and the door was soiled where it had been handled by people opening and closing the freezer. A large chest freezer, containing boxed frozen foods, was located behind the steam table and beside the cook top. The lid edges, and indented surface of the lid handle were soiled, and the interior seal on the freezer lid contained buildup of food particles and soil. There was a large amount of ice built up on the walls and boxes in the freezer. An upright freezer identified as used to store vegetables, was observed with food particles on the floor and shelves, and a brown colored substance had run from the lower shelf down the base of the freezer. The surface of the door was smudged and had residue on the edges and handle of the freezer. Observation on 4/27/26 at 10:30 a.m. of the area used for storage of food preparation equipment (scoops, spoons, spatulas, pans, skillets, and steam table pans) with the DM identified:5 of 13 quarter steam table pans that had been stacked, stored and remained wet. 4 of 13 had been stored unclean with food residue still present on the interior surface.2 of 8 half steam table pans were stored in the storage area and remained wet. 1 of 6 small square steam table pans in the storage area remained wet and contained food residue.5 of 12 full size steam table pans had been stored wet and contained food residue on the interior surface. The drawer containing serving spoons, scoops, and spatulas contained a wet spatula and scoop containing food residue. Interview on 4/27/26 at 10:45 a.m. with the DM confirmed the pans had not been adequately washed and should have been allowed to air dry before being stacked for storage. He then returned the identified items to the dishwashing area to be rewashed and sanitized. He reported his expectation for food storage equipment was for them to be cleaned daily, and any spills or build up on surfaces cleaned. The DM was not aware of when the freezers had last been cleaned and/or defrosted, but identified it needed to be on a schedule and monitored to ensure completion. Observation on 4/28/26 at 11:14 a.m. with cook (C)-A as he prepared menu items for the lunch meal, which consisted of spaghetti with meatballs, and tomato sauce, garlic toast, lettuce salad with dressing, and diced pears. C-A was observed preparing mashed potatoes, gravy, and altered texture items including pureed meat balls with sauce, and mechanically chopped spaghetti, with meatballs and sauce. C-A carried the large pot with boiling spaghetti from the stove to the sink across the kitchen and poured it into a colander in the sink. He took a spray hose from the top of the sink and sprayed water over the noodles. After draining he carried the colander from the sink and dumped the cooked noodles into a plastic lined steamtable pan. C-A washed his hands and applied gloves and continued opening drawers to retrieve scoops, which were placed in the steamtable pans, arranged bowls on a side and went into the walk-in cooler using his gloved hands to open the door, and returned carrying a plastic container of shredded lettuce, and a second container of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shredded cheese. He used his same gloved hands to remove the covers and place tongs in each of the containers. C-A began plating meals from the steamtable, turning lettuce into a bowl, added cheese and placed onto trays placed on the top counter of the steamtable, which the dietary aid covered and placed on the cart. After dishing several meals, C-A checked a menu slip, and preceded to go to the walk-in cooler, wearing same gloves, opened the door and retrieved a container of chicken salad. He used his same gloved hands to pick up a loaf of bread, opened it, reached in and removed 2 slices of bread which he held in his gloved hand. He then reached into the drawer that he opened with his right gloved hand and retrieved a scoop. He then placed the slices of bread on a plate, used his gloved hands to hold and remove the cover from the chicken salad, placed 2 scoops onto the bread, and used his gloved hand to place the second slice of bread on top and pushed it down. Further observation on 4/28/26 of the meal service identified C-A returned to the steam table and continued serving the meal with his same gloved hands, as he was plating noodles and adding meatballs and sauce. Some of the noodles would hang over the edge of the plate, and he used his gloved hand to put them back onto the plate, added a slice of bread with a fork and set the plate on the tray. C-A continued serving. At 12:15 p.m., C-A removed the glove from his right hand but continued wearing the same one on his left hand and went into the walk-in cooler and returned with a plastic container of cheese slices. He picked up the loaf of bread, removed 2 slices of bread which he placed on a plate, picked up each slice with his left hand, and held as he retrieved a spatula from the lower drawer, opened a container of butter and buttered both slices of bread, He then used his gloved hand to take out two slices of cheese which he placed on the buttered bread, and placed on a waiting tray. He reapplied a glove to his right hand and resumed serving from the steam table without first performing hand hygiene. At 12:30 p.m., C-A continued serving several more trays with the same process. C-A was then observed to have checked a tray slip, left the steam table to walk around to the other side of the room and use his gloved hands to move several items on the shelf and picked up a single serving package of jelly and peanut butter. He returned to the serving table, with no glove change or hand hygiene performed, and removed 2 slices of bread from the bag. He then opened the container of jelly with his gloved hand, used a table knife to spread on one slice of bread, and as he opened the peanut butter, it fell to the floor. C-A repeated the same processes throughout the service and failed to change his gloves and perform hand hygiene between tasks if he needed to leave the steam table. Interview on 4/28/26 at 5:00 p.m. with the DM confirmed C-A should have changed his gloves and performed hand hygiene between tasks, and anytime he had to leave and then return to serving at the steam table. He also identified C-A should have used a serving utensil to adjust food on a plate as it was not an acceptable practice to use a gloved hand. Review of the weekly cleaning log for 4/18/26 through 4/26/26, identified refrigerators and freezers were to be wiped down and were initiated as completed on 4/19/26, 4/12/26 and 4/5/26. The log failed to include cleaning of interior surfaces, seals, or hinges which contained a large amount of soil and food residue. The log also failed to include when freezers were to be defrosted and contained large amounts of ice built up on walls and items in the freezers. A policy on cleaning of the kitchen equipment was requested but not provided by the end of the survey period.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to ensure 4 of 5 sampled staff (nursing assistant (NA)-E, NA-F, AND NA-M) and dietary aide ((DA)-B) completed tuberculosis (TB) screening and testing upon hire. This had the potential to affect all 58 residents in the facility.Findings include: Review of employee health files for TB screening and testing identified:NA-E, with hire date of 2/4/26, had a TB screening completed on 3/13/26 and no TB testing completed. Review of NA-E time punches identified NA-E had worked 12 days since hire.DA-B, with hire date of 3/2/26, had undated TB screening completed, and 1st step TB test given on 2/9/26 and read on 2/11/26, however, the 2nd step TB test was given on 2/23/26 but never read.NA-M, with hire date of 1/21/26, there was no TB screening completed. NA-M did have their 1st and 2nd step TB test done and read.NA-F, with hire date of 3/17/26, had undated TB screening completed, and 1st TB test given on 3/23/26 and read on 3/26/26, however, there was no 2nd step TB completed. Interview on 4/29/26 at 12:32 p.m., with DON identified staff should have TB testing completed, the first step test should be completed upon hire prior to working with residents with the second step test to follow in about 2 weeks. Interview on 4/29/26 at 1:30 p.m., with human resource (HR) director identified typically the facility process was that new hires had a TB test completed on day one of employment. Then we follow up to see that the Mantoux test was checked and we let the staff know when they need to complete their second TB test. The staff TB form to document the test was typically left in the medication room for the nurse to complete. It was her responsibility to follow up with the nurse that the testing was completed and the form was filled out. She then would file in the TB form in the staff personnel file. Review of undated, Tuberculosis, Employee Screening policy identified new hired employees would be screened for latent tuberculosis infection (LTBI) and active tuberculosis (TB) disease using tuberculin skin test or interferon gamma release assay (IGRA) test and symptom screening prior to beginning employment. Employees will be screened for LTBI and TB disease after employment offer has been made and before duty assignment. The facility will accept TST and IGRA results within the last 90 days. If unable to obtain a skin test must be performed and negative reading obtained before beginning employment. Chest X-ray was also acceptable to rule out TB.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and document review, the facility failed to notify the Office of Ombudsman of a discharge for 1 of 2 sampled residents (R5). Findings include: R5's 12/26/25, accepted, Entry Tracking record identified R5 returned on 12/19/25, from a short-term general hospital stay. Additional 12/26/25, accepted significant change in status Minimum Data Set (MDS) assessment identified R5's cognition was intact. R5 used a walker, was independent with all his care with some set up assistance or supervision needed. R5 had diagnoses of anemia, heart failure, high blood pressure, thyroid disorder, and chronic obstructive pulmonary disease (COPD). R5's progress notes identified on:12/5/25, R5 had positive results of COVID and was placed on isolation.12/10/25, R5 cough was not improving, and primary care provider was notified.12/11/25, new orders for duo neb treatments three times a day for 5 days.12/14/25, R5 denied cough or headache. R5 reports his throat is sore. He reported he had thicker secretions and trouble swallowing but this had been happening before COVID. He requested his pills be crushed. The nurse offered to request an assessment by speech, however R5 had declined.12/17/25, nebulizer treatment and cough medicine administered at 10:00 a.m. R5's cough was noted to be worsening. R5's lung sounds were diminished and he had noted wheezing. R5 reported that he gets relief following the nebulizer treatment.12/17/25, due to worsening symptoms, he remained in isolation and received an order to complete a chest X-ray.12/17/25, ambulance transported R5 to the hospital related to worsening cough and complaint of shortness of breath.12/17/25, received an update from hospital and R5 was admitted for shortness of breath and weakness.12/19/25, R5 returned to the facility. Interview on 4/29/26 at 12:05 p.m., with social service designee (SSD) identified she was responsible for notifying the ombudsman when a resident was discharged . She sends the notices to the Ombudsman monthly. She found that R5's hospital discharge notice to the Ombudsman was not completed for his 12/17/25, discharge to the hospital. She was unsure why she had missed that notification. Interview on 4/30/26 at 8:28 a.m., with director of nursing (DON) identified that the SSD was responsible for notification to the Ombudsman when a resident discharged . She revealed that the SSD had been on vacation at the time and the facility should have a backup plan for things like that. She would expect that all discharges were reported to the Ombudsman. Review of undated, Transfer or Discharge Notice identified that the resident and/or representative will be notified in writing of discharge or transfers with a copy being sent to the Office of the State Long-Term Care Ombudsman.

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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. Based on interview and document review, the facility failed to revise the care plan for 1 of 1 sampled resident (R6) reviewed for pressure ulcers.Findings include: R6's 4/9/26, accepted Minimum Data Set (MDS) assessment identified R6 cognition was moderately impaired. R6 had limitations on one side of her lower extremity and required partial to substantial assistance for cares and transfers. R6 was at risk for developing pressure ulcers, used a pressure relieving device for her wheelchair and bed. During the assessment period R6 took antibiotic and diuretic. R6 had diagnoses of heart failure, arthritis, and depression. R6's 4/21/26, Skin Issues assessment identified a new pressure ulcer on the left dorsum (top side) 2nd digit (second toe). The pressure ulcer was identified as stage 2 (partial thickness skin loss with exposed dermis) that developed at the facility. The pressure ulcer was identified on 4/21/26 and measured 0.26 centimeters (cm) in length by 0.25 cm width and by 0.1 cm in depth. Bacitracin and a band aid was applied per primary care physician orders. The assessment identified R6 had been educated on leaving her shoe off due to pressure to toes and R6 had agreed. The care planning section of the assessment was blank and there were no further interventions or indication that the care plan would be revised following the identification of a new pressure ulcer. Review of 4/21/26, nursing progress note identified a new concern for R6's left 2nd toe with a review of R6's history of this toe. A wound assessment was completed, enhanced barrier precautions (EBP) were implemented, and the care plan was reviewed. There was an appointment set up for 4/22/26 with a provider who had seen R6 had seen prior related to her left toe. R6's current, undated care plan identified wound management of left 2nd toe with goal that wound would show signs of improvement. The interventions included measuring ulcers at regular intervals, monitoring ulcers for signs of infection, monitoring ulcers for signs of progression or declination, and provide wound care per treatment order. The care plan lacked the identification of leaving her shoe off due to pressure to toes as identified in the wound assessment. Interview on 4/28/26 at 10:34 a.m., with nursing assistant (NA)-B identified R6 had a sore on her left toe, but the nurse took care of that as it was preventative. She reported nurse aides did not do anything for R6's sore on her toe. Interview on 4/29/26 at 12:23 p.m., with NA-A identified she was unaware of any special interventions or anything that she was to do for R6's wound on her left toe. She reported that the nurse took care of R6's sore on her toe. Interview on 4/29/26 at 3:00 p.m., with the director of nursing (DON) identified she had completed the wound assessment and identified R6 she should take her shoes off as tolerated to relieve any pressure. She confirmed she had not put that intervention on the care plan for staff to encourage R6 to take her shoes off as tolerated. All nurses should be participating in resident care planning and revision when a resident needs changes to their care plan. She does complete reviews of care plans, and she should have revised R6's care plan to include the new intervention for her pressure wound. Review of the undated, Care Plans, Comprehensive Person-Centered policy identified assessments of resident's are ongoing and care plans are revised as resident's conditions change. The interdisciplinary team also reviews and updates the care plans when there has been a significant change in condition, the desired outcome has not been met, the resident was re-admitted from a hospital stay, and at least quarterly in conjunction with the MDS assessment.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and document review, the facility failed to ensure 1 of 5 staff had initial and annual Alzheimer's and dementia training. Findings include: Review of nursing assistant (NA)-G's employee file identified she had a hire date of 1/10/25. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Follow-up email reply on 4/29/26 at 5:08 p.m., from the director of nursing (DON) identified they were unable to locate NA-G's initial hiring documentation. An additional follow-up request for the DON's expectation for completion of initial Alzheimer's training was requested but not provided by the end of the survey period. Review of the current, undated In-Service Training policy identified all staff were required to participate in regular in-service education with an objective of ensuring staff were able to interact in a manner that enhanced the residents' quality of life and quality of care and could demonstrate competency in the topic areas of training. The required topics of training included effective communication with residents and families, resident rights, preventing abuse, dementia management and behavioral health. The training requirements were to be met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Completed training was to be documented with the date, time, topic, method, and summary of the competency.