Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 28, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: March 4, 2025

Dear Administrator:

On April 22, 2025, we informed you of imposed enforcement remedies.

On April 11, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 4, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 4, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Shores Of Worthington will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 4, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

Re: State Nursing Home Licensing Orders
Event ID: MNH711

Dear Administrator:

The above facility was surveyed on April 9, 2025 through April 11, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

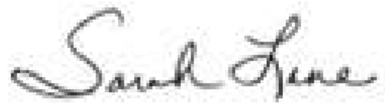
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00885	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/9/25, 4/10/25, and 4/11/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed:H55962445C (MN00111901) and H55962907C (MN00112208) with licensing orders issued at: 0900, 0910, and 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor and complete comprehensive skin assessments, evaluate the effectiveness of interventions, and provide physician ordered treatments as prescribed to prevent or negate the risk of deterioration or new	2 900	Corrected	5/8/25

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2 900	Continued From page 3 ulcer development for 1 of 3 residents (R1) who was at risk for pressure ulcers and had a history of pressure ulcers. Findings include: R1's face sheet dated 4/9/25, identified diagnoses of obesity. R1's quarterly Minimum Data Set (MDS) dated 1/11/25, identified no cognitive impairment. R1 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had frequent pain rated 10/10 with 10 as the worst pain ever experienced. R1 had a stage III pressure ulcer which indicated full thickness tissue loss. R1 had behaviors both verbal and physical directed at others, and rejected cares frequently. R1's wound evaluation dated 3/6/25, identified the stage III pressure ulcer to right ischial tuberosity was healed. R1's care plan dated 3/23/25, identified behavior management with interventions to attempt alternative time to provide care refused, monitor for signs and symptoms of infection. Pressure ulcer care dated 10/11/24, identified educate resident about proper skin care to prevent skin breakdown, encourage to frequently shift weight, provide skin care per facility guidelines, provide wound care per treatment order. Refused to sleep in bed and sleeps in the recliner per choice. R1's Braden scale for predicting pressure ulcer risk dated 4/8/25, identified a score of 13 which indicated moderate risk for pressure ulcers. R1's physician order dated 11/25/24, include the	2 900		

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2 900	Continued From page 4 order to apply a mixture of calmoseptime external ointment mixed with collagen fibers to bilateral buttocks topically two times per day. R1's corresponding treatment administration record (TAR) between 3/6/25 through 4/10/25 identified the calmoseptime with collegene was marked as completed, however R1's record between 3/6/25 through 4/10/25 did not include corresponding assessments and monitoring of the area for which the treatment was being applied. During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 demonstrated yelling behaviors toward all three staff during the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A sprayed peri-wash to the dried on bowel movement. RN-A began wiping bowel movement from both buttocks with wet wipes using her right hand. R1 stated his rectal area was very sore and to be careful. R1's bottom was noted to have many small, opened, red areas with bloody discharge on the right buttock and the left buttock had a heart shaped reddened area. RN-A stated they had some cream for that and squeezed a large amount of calmoseptime cream onto her right glove and rubbed it on bilateral buttocks pressure areas. RN-A did not mix the cream with collagen sprinkles nor measure the areas on R1's bottom. R1 began to scream and yelled "ouch" and "I told you it was sore down there!" NA-A took calmoseptime cream and squeezed some on right glove and put on creases of perineal region. NA-A removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink.	2 900		

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2 900	Continued From page 5 During an interview on 4/10/25 at 11:17 a.m., RN-A stated the areas on R1's buttocks are moisture related sores. The treatment was to apply calmoseptime to the areas. A medical doctor had not looked at the areas but the DON would complete the assessments. In a subsequent interview on 4/10/25 at 2:35 p.m., RN-A stated she notified DON that R1's buttocks needed to be evaluated due to a change in the wounds. RN-A verified that collagen sprinkles were not used during wound treatment. RN-A was not comfortable with wounds and staging and would refer to DON on determining what treatment would be best and what stage a pressure injury would be considered. R1 is hard because when he yells it creates a rushed environment and steps get missed. R1's late entry progress note dated 4/10/25 created at 5:39 p.m. for 11:17 a.m., identified buttocks changed in appearance and current orders are for calmoseptime. Notified director of nursing (DON) and resident agreed to lay down after supper for wound picture. Corresponding wound assessments dated 4/10/25 at 6:15 p.m., by DON identified stage III (resolved stage III) pressure injury to right ischial tuberosity measured area: <0.1 centimeters (CM), length: 0.22cm and width: 0.31 cm, no depth was identified. Left ischial tuberosity stage III (resolved stage III) pressure injury area 5.87cm, length 2.42cm, width 2.96cm, no depth was identified. Wound orders updated to apply to both buttocks: cleanse with Vashe wound cleanser, apply collagen to open areas, cover with silicone bordered foam. Change every 3 days and as needed. During an interview on 4/10/25 at 2:11 p.m., RN-B stated moisture associated skin breakdown	2 900		

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2 900	Continued From page 6 occurs when there is excessive moisture in an area. Once there is an area that has broken down it is more susceptible to breakdown. R1 is very adamant if he does not want to do something and the staff have to really try and coax him. RN-B would notify DON, and medical doctor if a change in wounds was noted. RN-B verified she was the nurse working with R1 on 4/9/25 and signed off that calmoseptime and collagen treatment had been completed. RN-B could not recall what condition the buttocks were in on 4/9/25 and did not remember looking at the wounds. During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated the DON completed weekly wound rounds on residents. Skin should be checked a minimum of weekly on bath days by the nurses. NA's should observe skin daily with cares and report changes to the nurse. Charting daily on the condition of wounds/wound dressing if the dressing is not scheduled to be changed is the expectation. R1 typically allowed the staff to transfer him from recliner to bed once a day. Every shift the staff encourage him to change positions. R1's current wound treatment was not appropriate for to treat R1's skin. The facility had wound training with a product specific company early in 2025 and they provided the facility with laminated cards for the NA's to direct what creams or lotions to use with specific skin issues. The DON has encouraged the nurses to come to her or the assistant director of nursing (ADON) if they were unsure about a wound. During an interview on 4/10/25 at 2:53 p.m., DON stated she observed wounds on residents weekly. RN-A informed DON to look at R1's buttocks as she was not confident in staging pressure ulcers. DON explained RN-A should have applied the	2 900		

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	00885	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

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2 900	Continued From page 7 treatment as ordered. Improper pericare could lead to infection and improper wound care could lead to worsening of wounds, both of which are negative outcomes. The facility Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 7/12/22, identified nursing staff and physician will assess and document an individuals significant risk factors for developing pressure ulcers. The physician will order pertinent wound treatments and help identify medical interventions related to wound management. The facility Wound Care procedure dated 9/29/21, identified to begin by verifying the physician order for the procedure. Document in the medical record: type of wound care given, all assessment data, etc. Report other information in accordance with facility policy and professional standards of practice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	2 900		

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2 900	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure appropriate care and services were provided to prevent urinary tract infections to the extent possible for 1 of 2 residents (R1) who had an indwelling urinary catheter. Findings include: R1's face sheet dated 4/15/25, identified diagnoses of overactive bladder (urgent need to urinate), atrophy of testes (shrinkage of one or	2 910	Corrected	5/8/25

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2 910	Continued From page 9 both testes), benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms (frequent/urgent need to urinate). R1's quarterly Minimum Data Set (MDS) dated 1/11/25, identified no cognitive impairment. R1 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had behaviors both verbal and physical directed at others and rejected cares frequently. R1's care plan dated 4/4/25, identified risk for urinary retention with foley catheter to be replaced monthly and as needed. Interventions included to evaluate for urinary complaints. R1 insisted that the catheter be placed. Monitor for abdominal distention and signs/symptoms of UTI. Evaluate for pain, urinary complaints, urine characteristics and cognitive changes. R1's physician order dated 8/30/24, identified an order for a urinary catheter 16 french 10 cubic centimeters (CC) balloon be placed, changed monthly with a diagnosis of urinary incontinence. R1's progress note dated 12/5/25, identified R1 returned from emergency department with a diagnosis of acute cystitis (inflammation of bladder often caused by bacteria) with hematuria (blood in urine). Start ciprofloxacin (antibiotic) twice daily for days. Maintain foley catheter with a 24 french 10 cc balloon. R1's physician order dated 1/5/25, included an order for 24 french catheter with 10 cc balloon. During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated she was unable to find specific culture results for the UTI	2 910		

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2 910	Continued From page 10 but that R1 went to the emergency department for treatment on 12/5/25. R1's progress note dated 3/6/25, identified urine analysis and urine culture (UA/UC) results from 3/5/25 were positive for a UTI. Will treat with Keflex (antibiotic). During an interview on 4/10/25 at 12:20 p.m., IP-A stated the UC growth showed ecoli and enterococcis faccaeilis. Reviewed that these bacteria spread from direct or indirect contact with healthcare workers hands. R1's progress note dated 3/7/25, identified foley catheter changed, urine dark with sediment, when pulled out tubing tip was full of mucous. Located a 20 french with 30cc balloon, 24 french was not available as ordered by the physician on 1/5/25. R1's progress note dated 4/4/25, identified UA/UC was ordered due to R1 having coke colored urine with blood present, and hallucinations. R1's progress note dated 4/5/25, identified UA was collected and ready to be sent to the lab. R1's record did not include the lab results. R1's progress note dated 4/7/25, indicated a physician order for Macrobid (antibiotic) two times a day for seven days started. Repeat UA in seven days. During an interview on 4/10/25 at 12:20 p.m., IP-A stated the bacteria that grew from the UC from 4/5/25, had multiple morphotypes present. IP-A went onto the computer and looked up what mulitiple morphotypes could be caused by and stated this bacteria can also be spread by direct	2 910		

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2 910	Continued From page 11 or indirect contact with healthcare workers hands. During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 had yelling behaviors directed at staff throughout the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A wiped with her right hand in penile area and NA-B sprayed periwash on the dried stool dried on to and adheared to R1's bottom area. As NA-B cleaned the stool in an upward motion across R1's scrotum and by the catheter R1 yelled that it hurt. NA-A then took a wet washcloth and wiped on the groin creases and bowel movement was present on the washcloth. NA-A had NA-B rinse the washcloth in the filled water basin. NA-A took the same wash cloth from the basin and wiped the creases again. NA-A then moved to R1's penis and wiped around the catheter tip and then down the catheter tubing with the dirty washcloth. NA-A used a clean, dry towel to dry the areas. NA-A then moved the catheter tubing with her right gloved hand to move it out of the way while R1 was turned to his left side. Without changing gloves and santizing hands, NA-A took calmoseptine cream and squeezed some on right glove and put on creases of perineal region. NA-A then removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on without performing hand hygiene. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink. During an interview on 4/10/25 at 12:20 p.m., IP-A stated an investigation/analysis has not been completed nor surveillance activities such as audits in order to identify potential causal factors of R1's repeated UTI's so that interventions could	2 910		

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2 910	Continued From page 12 be developed and implemented to prevent or reduce the risk. IP-A expected staff were to perform pericare following infection control guidelines. During an interview on 4/10/25 at 2:53 p.m., DON stated there had not been surveillance activities that addressed catheter related infections. If staff were not providing personal cares appropriately, that could lead to infection. DON and the ADON would be, but have not started, working on providing education and competencies with staff on catheter cares and pericares. During an interview on 4/11/25 at 11:36a.m., DON and IP-A stated the facility will increase fluids on residents with catheters. R1 preferred to drink mountain dew and was not good at drinking water. The nurses monitor for cognitive symptoms in R1 since the UTI he currently has, he was noted to have hallucinations as a symptom. Proper hand hygiene should be performed with pericares. The facility Urinary Catheter Care dated 11/1/21, identified to maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. It is not recommended to change the indwelling catheters or bags at fixed, routine intervals and instead based on clinical indications such as infection. Observe the resident for complications associated with urinary catheters. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The	2 910		

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2 910	Continued From page 13 results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/8/25

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21390	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to perform appropriate hand hygiene during cares for 4 of 4 residents (R3, R4, R5, and R10) observed for personal cares. Findings include: R3 R3's face sheet dated 4/15/25, identified diagnoses of intertrochanteric fracture of left femur (broken hip). R3's care plan dated 3/25/25, identified personal hygiene required extensive assistance from staff. During an observation on 4/10/25 at 7:46 a.m., R3 was in bed. nursing assistant (NA)-A filled basin with water and applied gloves. Cleansed top half of body and face. Had R3 turn to the side and wiped bowel movement with wipes. NA-A without performing hand hygiene, returned to the front of R3 and cleaned penis pulling down foreskin and wiping away white particles with a washcloth. NA-A then took off gloves and without performing hand hygiene left and returned to R3's room and without performing hand hygiene put new gloves on. NA-A instructed R3 to turn and washed bottom with wipe. NA-A then took the washcloth to remove the remaining stool from R3's bottom. NA-A put the washcloth in the water basin to rinse it out. NA-A then used that same washcloth from the dirty water and finished cleaning R3's bottom. While wearing the same gloves NA-A dried R3's bottom area and applied a new incontinent brief. Rinsed basin out in sink and emptied water into toilet. NA-A removed	21390	Corrected	

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21390	Continued From page 15 gloves and without performing hand hygiene gave R3 his call light and then washed her hands. R4 R4's face sheet dated 4/10/25, identified moderate intellectual disabilities. R4's care plan dated 8/20/24, identified R4 required assistance of two staff and mechanical standing lift for toileting. During an observation on 4/10/25 at 8:23 a.m., R4 was seated on the commode (portable toilet) with the mechanical standing lift attached. NA-A and NA-B applied gloves. NA-B lifted R4 into a half standing position with the machine while NA-A cleaned bowel movement from R4's bottom area. R4 stated that it was sore. NA-A stated she would put ointment on when finished wiping. NA-A moved to R4's front and wiped peri area with the same gloved hand used to wipe the backside. NA-A removed the glove after wiping, grabbed a tube of preventative ointment and applied to rectal area. Removed other glove and pulled up R4's pants and incontinent product. NA-A applied another set of gloves to clean commode. Removed gloves when finished. Both NA's washed hands at R4's sink. R5 R5's face sheet dated 4/10/25, identified fracture of upper and lower end of right fibula (broken calf bone), and fracture of medial malleolus of right tibia (the bump on the side of the ankle). R5's care plan dated 4/8/25, identified R5 required assistance of two staff and mechanical lift for transfers. During an observation on 4/10/25 at 8:10 a.m.,	21390		

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21390	Continued From page 16 NA-A applied enhanced barrier precautions (EBP gown, gloves, mask) and entered room. NA-B was inside R5's room and opened the door. NA-B stepped out of the room and applied EBP. R5 was in the room attached to mechanical lift on the commode. NA-A and NA-B transferred R5 from the commode to the bed and removed the mechanical lift. NA-A wiped R5's bottom. Applied pants on R5's legs and incontinent product by rolling R5 side to side. Re-attached mechanical lift to R5. Transferred R5 to wheelchair and adjusted R5's shirt and boosted back in the wheelchair to R5's comfort. Gave R5 the call light and placed overhead table in front of wheelchair. Removed EBP and sanitized hands. R10 R10's face sheet dated 4/15/25, identified diagnoses of parkinsonism (difficulties with movement). R10's care plan dated 2/17/25, identified R10 required extensive assistance with personal hygiene. During an observation on 4/10/25 at 7:06 a.m., R10 was laying in bed. NA-C filled water in a basin.Applied gloves. Asked R10 to remove dentures so they could be brushed, removed and put in container to soak during cares. Washed face and abdominal region with soap and water after removing gown. After drying R10, applied a shirt. Opened brief and cleansed peri area. Grabbed another washcloth and cleaned backside. Put on a new incontinent product. Removed gloves and put a new pair on. Put a few gloves in her pocket. Put pants on. Had R10 sit on the edge of bed, put on socks, put walker in front of him. Transferred to wheelchair. Removed gloves and sanitized hands.	21390		

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21390	Continued From page 17 During an interview on 4/10/25 at 8:36 a.m., NA-B stated that handwashing is done between residents. During an interview on 4/10/25 at 9:45 a.m., NA-C stated handwashing is done in the morning, on breaks, if bowel movements are bad and messy, otherwise hand sanitizer after exiting rooms. NA-C was unaware about handwashing between removing and applying new gloves. During an interview on 4/10/25 at 9:53 a.m., NA-A stated handwashing is used after coming in contact with a resident or leaving the room. It should be done between glove changes, I forgot. During an interview on 4/10/25 at 2:35 p.m., registered nurse (RN)-A stated hand sanitizing is done throughout the day, in between glove changes. Wash hands before and after cares. During an interview on 4/11/25 at 9:47 a.m., licensed practical nurse (LPN)-A stated management monitors, teaches, and reinforces hand hygiene and the importance of handwashing between pericare. During an interview on 4/10/25 at 12:20 p.m., registered nurse infection preventionist (IP)-A stated the staff should wash or sanitize hands after glove removal and should change gloves and sanitize or handwash after cleaning the peri area whether front or back. Staff should not clean bowels and use the same gloved hand or cleaning utensil to clean the front side. During an interview on 4/10/25 at 2:53 p.m., director of nursing (DON) stated they [management] observe a ton of handwashing,	21390		

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21390	Continued From page 18 applying and removing gloves that are a month or two old. Nothing good can come of improper peri care, it could lead to an infection. Hand washing and/or sanitizing should be done more often than it is apparently. We have been pushing staff to wash hands when removing gloves and use the sink, it is available in every room. If cleaning something dirty, remove gloves, wash/sanitize hands, put on new gloves, it is not worth it to cross-contaminate. The facility policy Perineal Care dated 2/8/22, identified the procedure was to provide cleanliness to the resident, prevent infections and skin irritation. For a female resident wash perineal area, wiping front to back. Wash the rectal area wiping from the base of the labia towards and extending over the buttocks. For a male resident wash perineal area starting with urethra and working outward. Wash rectal area thoroughly including under the scrotum, the anus, and buttocks. SUGGESTED METHOD OF CORRECTION: The Infection Control Preventionist (ICP) or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21	21390		

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21390	Continued From page 19 (twenty-one) DAYS	21390		

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	245596	A. BUILDING _____ B. WING _____	C 04/11/2025

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THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/9/25, 4/10/25, and 4/11/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55962445C (MN00111901), and H55962907C (MN00112208) with deficiencies cited at F686, F684, F880, and F690. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/8/25

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

Electronically Signed | 05/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 Based on observation, interview, and record review the facility failed to comprehensively assess and treat impaired skin integrity for 1of 1 residents (R3) who had acute dermatitis. Findings include: R3's face sheet dated 4/15/25, identified diagnoses of type two diabetes, obesity. R3's admission Minimum Data Set (MDS) dated 3/24/25, identified no cognitive deficits. Frequent incontinence of bladder and bowel. R3's care plan dated 3/25/25, identified R3 required extensive assistance with person hygiene and toilet use. R3's care plan dated 3/31/25, identified risk for impaired skin integrity and to monitor for moisture, apply barrier product as needed. A goal dated 4/4/25 included, skin integrity would be evaluated. Corresponding intervention directed staff to evaluate skin integrity. R3's hospital discharge orders dated 3/18/25, identified an order for bacitracin-neomycin-polymyxin 5-400-5000 milligrams (mg) unit ointment and apply 1 application twice daily to rash until clear. Clotrimazole 1% cream apply topically three times per day as needed, no diagnosis indicated. Hydrocortisone butyrate 0.1% cream apply one application topically three times per day as needed for rash. Triamcinolone acetonide 0.1% cream apply topically to affected areas twice daily as needed for atopic dermatitis. Interdry AG textile to opposing skin folds for prevention or treatment of irritated skin. Change every five days or if soiled. Leave a two inch "tail" outside of each	F 684	R3□s MD was updated on resident skin breakdown and MD orders were updated as needed. R3 had a new Braden Assessment and skin check was completed and documented, the care plan and bathing preference was reviewed and updated as needed. Current residents who are at high risk for skin breakdown, their weekly bath audits, skilled documentation, care plans and skin documentation (if wound is present) were reviewed and updated as needed. Future residents who admit will have a Braden completed and changes in skin will be reported to the nurse per facility policy. The facility nursing and nurse aides will be in-serviced on the facility Medline skin formulary along with the Physician Standing Order Policy which indicates immediate interventions that can be applied to address skin concerns. In addition, RN-A will have 1:1 in-service education on the facility Charting and Documentation policy with emphasis on documentation should reflect objective observations, changes in resident conditions and treatments or services performed, and any reports of new concerns must immediately be addressed. Director of Nursing and/or designee will be responsible for compliance. Audits on reported new skin concerns, was a comprehensive assessment conducted, immediate skin intervention initiated, and review of the bath audit will begin 2x week for 2 weeks, weekly x 5 weeks then monthly to ensure sustained compliance.	

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F 684	Continued From page 2 end of affected area to wick away moisture. R3's physician orders dated 3/18/25 identified the aforementioned physician orders according to the hospital discharge summary. Review of R3's medication administration record (MAR) for March and April 2025, identified the treatment orders but there was no indication R3's skin care treatments were applied. The admission skin assessment dated 3/18/25 did not identify an issues with R3's skin. R3's progress note dated 3/18/25 at 1:29 p.m., identified the note as a nurse to nurse report from hospital. Under folds increased moisture and redness. R3's progress note dated 3/19/25 at 12:22 p.m., indicated R3's "rash" had healed. R3's skilled evaluation progress note dated 4/9/25 at 11:43 p.m., identified no skin issues on abdomen or groin area. During an observation on 4/10/25 at 7:46 a.m., R3 was in bed. Nursing assistant (NA)-A filled basin with water and applied gloves to provide morning cares. NA-A removed R3's brief. R3's abdomen was reddened across the whole apron fold and groin area was very red on both sides. NA-A stated R3's abdomen looked a little sore/red across the whole abdominal fold and was very red in the groin area on the creases. NA-A then dried the areas she had just cleaned and applied a new incontinent brief. NA-A left the R3's room and returned to the room with an antifungal cream and an antifungal powder. NA-A	F 684	Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/8/2025	

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F 684	Continued From page 3 stated she would use the antifungal cream as the area was not moist but leave the powder in the room also; she the applied antifungal cream to abdominal fold and groin creases. NA-A left the room, walked to registered nurse (RN)-A and notified RN-A that R3 was ready for a breakfast tray. NA-A did not mention R3's reddened folds. During an observation and interview on 4/10/25 at 12:20 p.m., registered nurse infection preventionist (IP)-A stated skin should be checked at a minimum weekly during a bath. NA's should be doing a daily check during morning and evening cares. A notable change should be reported to the nurse. IP-A explained R3 had been admitted from the hospital, the hospital had reported to the facility R3 had redness under folds and moisture, but the facility did not see that when he admitted. When the initial assessment was completed, the staff verify skin conditions, and the facility charting did not show concerns in that area. IP-A went to R3's room and put gloves on. IP-A lowered pants and lifted abdominal fold and stated that the areas were definitely red and moist. R3 indicated he had a history of problems in that area. This facility was not providing enough hygiene. The facility where he resided at prior and would be returning to had given him showers four times a week, had three times a week in a bath with jets, and used a medicated spray to manage the skin issues. This facility could not provide him with bathing due to his condition. IP-A stated the issue should have been reported to the nurse, medical doctor notified. The area needed to have the moisture removed to decrease redness. If this goes untreated it could lead to sores/infection. IP-A felt that a powder and Interdry would be a good treatment for the areas. Education should be	F 684		

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F 684	Continued From page 4 done on cleaning and drying the folds as well. During an interview on 4/10/25 at 2:35 p.m., RN-A stated she looked at R3's skin after NA-A said to look at it because it was very sore. RN-A got busy and behind in work, IP-A also told her about R3's skin, and thought a fax was started to send to the physician. This was the first time it was reported to her that R3 had a red groin. RN-A explained skin issues would be documented under the skin section of the daily skilled charting notes. RN-A reviewed the record and identified there was nothing documented pertaining to the condition. RN-A relied on the NA's to tell her if a resident had new skin issues so that the area would be assessed. During an interview on 4/10/25 at 2:53 p.m., director of nursing (DON) stated the floor nurses have had education on what to look for with skin concerns. DON would expect the NA's to notify the floor nurse of a skin concern and the nurse would examine and determine next steps. DON was unsure if antifungal could be given as a standing order but typically would call or send a fax to the physician for orders. If care and treatment were provided improperly or not at all, "nothing good could come of it". Improper treatment of wounds could lead to worsening wound(s) and if medications were given incorrectly, that could lead to a negative outcome. During an interview on 4/11/25 at 2:24 p.m., DON and IP-A stated there have been discrepancies between what the hospital reports and what the resident actually has when they enter the building regarding wounds and dressings. It was absolutely not appropriate and out of the scope of practice for an NA to choose what product to	F 684		

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F 684	Continued From page 5 apply on a resident. The facility Wound Care procedure dated 9/29/21, identified to begin by verifying the physician order for the procedure. Document in the medical record: type of wound care given, all assessment data, etc. Report other information in accordance with facility policy and professional standards of practice.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor and complete comprehensive skin assessments, evaluate the effectiveness of interventions, and provide physician ordered treatments as prescribed to prevent or negate the risk of deterioration or new ulcer development for 1 of 3 residents (R1) who was at risk for pressure ulcers and had a history of pressure ulcers.	F 686	R1 had a new pain assessment, skin assessment with photos and a new Braden Assessment completed on 5/2/2025. R1□s MD was informed that the resident did not receive the ordered treatment per MD order and the resident indicated pain during the treatment. MD□s response along with any new orders will be recorded in the resident electronic medical record. Current	5/8/25

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F 686	Continued From page 6 Findings include: R1's face sheet dated 4/9/25, identified diagnoses of obesity. R1's quarterly Minimum Data Set (MDS) dated 1/11/25, identified no cognitive impairment. R1 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had frequent pain rated 10/10 with 10 as the worst pain ever experienced. R1 had a stage III pressure ulcer which indicated full thickness tissue loss. R1 had behaviors both verbal and physical directed at others, and rejected cares frequently. R1's wound evaluation dated 3/6/25, identified the stage III pressure ulcer to right ischial tuberosity was healed. R1's care plan dated 3/23/25, identified behavior management with interventions to attempt alternative time to provide care refused, monitor for signs and symptoms of infection. Pressure ulcer care dated 10/11/24, identified educate resident about proper skin care to prevent skin breakdown, encourage to frequently shift weight, provide skin care per facility guidelines, provide wound care per treatment order. Refused to sleep in bed and sleeps in the recliner per choice. R1's Braden scale for predicting pressure ulcer risk dated 4/8/25, identified a score of 13 which indicated moderate risk for pressure ulcers. R1's physician order dated 11/25/24, include the order to apply a mixture of calmoseptime external ointment mixed with collagen fibers to bilateral buttocks topically two times per day. R1's	F 686	residents who have open wounds, their Braden, treatment orders and care plan were reviewed and updated as needed. Future residents who experience skin alterations, the licensed nurse will utilize the physician standing orders to implement the appropriate treatment per facility policy. Nurse Aides were in-serviced on their job description which indicates they are to report skin concerns to the nurse and that they are not to apply topical medications as this is a task specifically for the licensed nurse and is out of their scope of practice. Licensed nurses were in-serviced on storing treatment medications in the treatment cart and administering treatments per MD order. The facility nursing and nurse aides will be in-serviced on the facility Medline skin formulary along with the Physician Standing Order Policy which indicates immediate interventions that can be applied to address skin concerns and will have education on the facility Charting and Documentation policy with emphasis on documentation should reflect objective observations, changes in resident conditions and treatments or services performed, and any reports of new concerns must immediately be addressed. Director of Nursing and/or designee is responsible for compliance. Audits on resident wound location, was the wound assessed weekly, wound improvement/decline documentation, ordered treatment applied, and visual treatment completion by the licensed	

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F 686	Continued From page 7 corresponding treatment administration record (TAR) between 3/6/25 through 4/10/25 identified the calmoseptime with collegene was marked as completed, however R1's record between 3/6/25 through 4/10/25 did not include corresponding assessments and monitoring of the area for which the treatment was being applied. During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 demonstrated yelling behaviors toward all three staff during the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A sprayed peri-wash to the dried on bowel movement. RN-A began wiping bowel movement from both buttocks with wet wipes using her right hand. R1 stated his rectal area was very sore and to be careful. R1's bottom was noted to have many small, opened, red areas with bloody discharge on the right buttock and the left buttock had a heart shaped reddened area. RN-A stated they had some cream for that and squeezed a large amount of calmoseptime cream onto her right glove and rubbed it on bilateral buttocks pressure areas. RN-A did not mix the cream with collagen sprinkles nor measure the areas on R1's bottom. R1 began to scream and yelled "ouch" and "I told you it was sore down there!" NA-A took calmoseptime cream and squeezed some on right glove and put on creases of perineal region. NA-A removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink. During an interview on 4/10/25 at 11:17 a.m., RN-A stated the areas on R1's buttocks are	F 686	nurse will begin 2x week for 2 weeks, weekly x 6 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/8/2025	

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F 686	Continued From page 8 moisture related sores. The treatment was to apply calmoseptime to the areas. A medical doctor had not looked at the areas but the DON would complete the assessments. In a subsequent interview on 4/10/25 at 2:35 p.m., RN-A stated she notified DON that R1's buttocks needed to be evaluated due to a change in the wounds. RN-A verified that collagen sprinkles were not used during wound treatment. RN-A was not comfortable with wounds and staging and would refer to DON on determining what treatment would be best and what stage a pressure injury would be considered. R1 is hard because when he yells it creates a rushed environment and steps get missed. R1's late entry progress note dated 4/10/25 created at 5:39 p.m. for 11:17 a.m., identified buttocks changed in appearance and current orders are for calmoseptime. Notified director of nursing (DON) and resident agreed to lay down after supper for wound picture. Corresponding wound assessments dated 4/10/25 at 6:15 p.m., by DON identified stage III (resolved stage III) pressure injury to right ischial tuberosity measured area: <0.1 centimeters (CM), length: 0.22cm and width: 0.31 cm, no depth was identified. Left ischial tuberosity stage III (resolved stage III) pressure injury area 5.87cm, length 2.42cm, width 2.96cm, no depth was identified. Wound orders updated to apply to both buttocks: cleanse with Vashe wound cleanser, apply collagen to open areas, cover with silicone bordered foam. Change every 3 days and as needed. During an interview on 4/10/25 at 2:11 p.m., RN-B stated moisture associated skin breakdown occurs when there is excessive moisture in an	F 686		

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F 686	Continued From page 9 area. Once there is an area that has broken down it is more susceptible to breakdown. R1 is very adamant if he does not want to do something and the staff have to really try and coax him. RN-B would notify DON, and medical doctor if a change in wounds was noted. RN-B verified she was the nurse working with R1 on 4/9/25 and signed off that calmoseptime and collagen treatment had been completed. RN-B could not recall what condition the buttocks were in on 4/9/25 and did not remember looking at the wounds. During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated the DON completed weekly wound rounds on residents. Skin should be checked a minimum of weekly on bath days by the nurses. NA's should observe skin daily with cares and report changes to the nurse. Charting daily on the condition of wounds/wound dressing if the dressing is not scheduled to be changed is the expectation. R1 typically allowed the staff to transfer him from recliner to bed once a day. Every shift the staff encourage him to change positions. R1's current wound treatment was not appropriate for to treat R1's skin. The facility had wound training with a product specific company early in 2025 and they provided the facility with laminated cards for the NA's to direct what creams or lotions to use with specific skin issues. The DON has encouraged the nurses to come to her or the assistant director of nursing (ADON) if they were unsure about a wound. During an interview on 4/10/25 at 2:53 p.m., DON stated she observed wounds on residents weekly. RN-A informed DON to look at R1's buttocks as she was not confident in staging pressure ulcers. DON explained RN-A should have applied the	F 686		

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F 686	Continued From page 10 treatment as ordered. Improper pericare could lead to infection and improper wound care could lead to worsening of wounds, both of which are negative outcomes. The facility Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 7/12/22, identified nursing staff and physician will assess and document an individuals significant risk factors for developing pressure ulcers. The physician will order pertinent wound treatments and help identify medical interventions related to wound management. The facility Wound Care procedure dated 9/29/21, identified to begin by verifying the physician order for the procedure. Document in the medical record: type of wound care given, all assessment data, etc. Report other information in accordance with facility policy and professional standards of practice.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		5/8/25

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F 690	Continued From page 11 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure appropriate care and services were provided to prevent urinary tract infections to the extent possible for 1 of 2 residents (R1) who had an indwelling urinary catheter. Findings include: R1's face sheet dated 4/15/25, identified diagnoses of overactive bladder (urgent need to urinate), atrophy of testes (shrinkage of one or both testes), benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms (frequent/urgent need to urinate). R1's quarterly Minimum Data Set (MDS) dated 1/11/25, identified no cognitive impairment. R1	F 690	An order was placed for the correct sizes of catheters on 04/18/2025. R1□s MD was contacted and informed that the wrong size catheter was inserted and that the proper hand hygiene was performed during peri-care. The MDs response will be entered into the resident medical record. Current residents with foley catheter□s, their MDs were contacted for updated foley catheter change orders. Future residents who are admitted to the facility, their MD orders for foley changes will follow current facility policy. Facility nurses and nurse aides were in-serviced on the Urinary Catheter Care policy with emphasis on maintaining clean technique when handling or manipulating the catheter and not changing indwelling	

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F 690	Continued From page 12 was dependent with cares on lower body. Had an indwelling urinary catheter, always incontinent of bowels. R1 had behaviors both verbal and physical directed at others and rejected cares frequently. R1's care plan dated 4/4/25, identified risk for urinary retention with foley catheter to be replaced monthly and as needed. Interventions included to evaluate for urinary complaints. R1 insisted that the catheter be placed. Monitor for abdominal distention and signs/symptoms of UTI. Evaluate for pain, urinary complaints, urine characteristics and cognitive changes. R1's physician order dated 8/30/24, identified an order for a urinary catheter 16 french 10 cubic centimeters (CC) balloon be placed, changed monthly with a diagnosis of urinary incontinence. R1's progress note dated 12/5/25, identified R1 returned from emergency department with a diagnosis of acute cystitis (inflammation of bladder often caused by bacteria) with hematuria (blood in urine). Start ciprofloxacin (antibiotic) twice daily for days. Maintain foley catheter with a 24 french 10 cc balloon. R1's physician order dated 1/5/25, included an order for 24 french catheter with 10 cc balloon. During an interview on 4/10/25 at 12:20 p.m., infection preventionist (IP)-A stated she was unable to find specific culture results for the UTI but that R1 went to the emergency department for treatment on 12/5/25. R1's progress note dated 3/6/25, identified urine analysis and urine culture (UA/UC) results from	F 690	catheters or bags at fixed, routine intervals unless clinical indications suggest infection. Infection Preventionist and/or designee is responsible for compliance. Audits on catheter care competency and hand hygiene will begin 2x week x 4 weeks, weekly x 3 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/8/2025	

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F 690	Continued From page 13 3/5/25 were positive for a UTI. Will treat with Keflex (antibiotic). During an interview on 4/10/25 at 12:20 p.m., IP-A stated the UC growth showed ecoli and enterococcis faccaeilis. Reviewed that these bacteria spread from direct or indirect contact with healthcare workers hands. R1's progress note dated 3/7/25, identified foley catheter changed, urine dark with sediment, when pulled out tubing tip was full of mucous. Located a 20 french with 30cc balloon, 24 french was not available as ordered by the physician on 1/5/25. R1's progress note dated 4/4/25, identified UA/UC was ordered due to R1 having coke colored urine with blood present, and hallucinations. R1's progress note dated 4/5/25, identified UA was collected and ready to be sent to the lab. R1's record did not include the lab results. R1's progress note dated 4/7/25, indicated a physician order for Macrobid (antibiotic) two times a day for seven days started. Repeat UA in seven days. During an interview on 4/10/25 at 12:20 p.m., IP-A stated the bacteria that grew from the UC from 4/5/25, had multiple morphotypes present. IP-A went onto the computer and looked up what mulitiple morphotypes could be caused by and stated this bacteria can also be spread by direct or indirect contact with healthcare workers hands. During an observation on 4/10/25 at 10:49 a.m., nursing assistant (NA)-A, NA-B, and registered	F 690		

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F 690	Continued From page 14 nurse (RN)-A entered R1's room to provide cares all wearing a gown, mask, and gloves. R1 had yelling behaviors directed at staff throughout the episode of care. NA-A detached the tabs of the brief. Bowel movement present. NA-A wiped with her right hand in penile area and NA-B sprayed periwash on the dried stool dried on to and adheared to R1's bottom area. As NA-B cleaned the stool in an upward motion across R1's scrotum and by the catheter R1 yelled that it hurt. NA-A then took a wet washcloth and wiped on the groin creases and bowel movement was present on the washcloth. NA-A had NA-B rinse the washcloth in the filled water basin. NA-A took the same wash cloth from the basin and wiped the creases again. NA-A then moved to R1's penis and wiped around the catheter tip and then down the catheter tubing with the dirty washcloth. NA-A used a clean, dry towel to dry the areas. NA-A then moved the catheter tubing with her right gloved hand to move it out of the way while R1 was turned to his left side. Without changing gloves and santizing hands, NA-A took calmoseptine cream and squeezed some on right glove and put on creases of perineal region. NA-A then removed gloves and asked NA-B to get her a new pair. NA-A put new gloves on without performing hand hygiene. After transferring back to the recliner NA-A, NA-B, and RN-A removed gloves and washed hands in sink. During an interview on 4/10/25 at 12:20 p.m., IP-A stated an investigation/analysis has not been completed nor surveillance activities such as audits in order to identify potential causal factors of R1's repeated UTI's so that interventions could be developed and implemented to prevent or reduce the risk. IP-A expected staff were to perform pericare following infection control	F 690		

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F 690	Continued From page 15 guidelines. During an interview on 4/10/25 at 2:53 p.m., DON stated there had not been surveillance activities that addressed catheter related infections. If staff were not providing personal cares appropriately, that could lead to infection. DON and the ADON would be, but have not started, working on providing education and competencies with staff on catheter cares and pericares. During an interview on 4/11/25 at 11:36a.m., DON and IP-A stated the facility will increase fluids on residents with catheters. R1 preferred to drink mountain dew and was not good at drinking water. The nurses monitor for cognitive symptoms in R1 since the UTI he currently has, he was noted to have hallucinations as a symptom. Proper hand hygiene should be performed with pericares. The facility Urinary Catheter Care dated 11/1/21, identified to maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. It is not recommended to change the indwelling catheters or bags at fixed, routine intervals and instead based on clinical indications such as infection. Observe the resident for complications associated with urinary catheters.	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		5/8/25

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F 880	Continued From page 16 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 17 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to perform appropriate hand hygiene during cares for 4 of 4 residents (R3, R4, R5, and R10) observed for personal cares. Findings include: R3 R3's face sheet dated 4/15/25, identified diagnoses of intertrochanteric fracture of left femur (broken hip). R3's care plan dated 3/25/25, identified personal hygiene required extensive assistance from staff. During an observation on 4/10/25 at 7:46 a.m., R3 was in bed. nursing assistant (NA)-A filled	F 880	NA-A, NA-B, NA C were given 1:1 in-service on Hand Hygiene Policy and oral care and peri care competencies were completed. R5, R10 and R4□s MD were made aware that hand hygiene was not performed by facility policy. There were no ill effects experienced by residents for this deficient process. Current and future residents who require assistance for ADL care, hand hygiene will be performed at the correct sequence per facility policy. Facility staff will be in-serviced on the in-serviced on Hand Hygiene Policy with emphasis on item #7 which lists when hand hygiene must take place. Infection Preventionist and/or designee is responsible for compliance.	

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F 880	Continued From page 18 basin with water and applied gloves. Cleansed top half of body and face. Had R3 turn to the side and wiped bowel movement with wipes. NA-A without performing hand hygiene, returned to the front of R3 and cleaned penis pulling down foreskin and wiping away white particles with a washcloth. NA-A then took off gloves and without performing hand hygiene left and returned to R3's room and without performing hand hygiene put new gloves on. NA-A instructed R3 to turn and washed bottom with wipe. NA-A then took the washcloth to remove the remaining stool from R3's bottom. NA-A put the washcloth in the water basin to rinse it out. NA-A then used that same washcloth from the dirty water and finished cleaning R3's bottom. While wearing the same gloves NA-A dried R3's bottom area and applied a new incontinent brief. Rinsed basin out in sink and emptied water into toilet. NA-A removed gloves and without performing hand hygiene gave R3 his call light and then washed her hands. R4 R4's face sheet dated 4/10/25, identified moderate intellectual disabilities. R4's care plan dated 8/20/24, identified R4 required assistance of two staff and mechanical standing lift for toileting. During an observation on 4/10/25 at 8:23 a.m., R4 was seated on the commode (portable toilet) with the mechanical standing lift attached. NA-A and NA-B applied gloves. NA-B lifted R4 into a half standing position with the machine while NA-A cleaned bowel movement from R4's bottom area. R4 stated that it was sore. NA-A stated she would put ointment on when finished wiping. NA-A moved to R4's front and wiped peri area	F 880	Audits on hand hygiene performed at correct sequenced intervals will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/8/2025	

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F 880	Continued From page 19 with the same gloved hand used to wipe the backside. NA-A removed the glove after wiping, grabbed a tube of preventative ointment and applied to rectal area. Removed other glove and pulled up R4's pants and incontinent product. NA-A applied another set of gloves to clean commode. Removed gloves when finished. Both NA's washed hands at R4's sink. R5 R5's face sheet dated 4/10/25, identified fracture of upper and lower end of right fibula (broken calf bone), and fracture of medial malleolus of right tibia (the bump on the side of the ankle). R5's care plan dated 4/8/25, identified R5 required assistance of two staff and mechanical lift for transfers. During an observation on 4/10/25 at 8:10 a.m., NA-A applied enhanced barrier precautions (EBP gown, gloves, mask) and entered room. NA-B was inside R5's room and opened the door. NA-B stepped out of the room and applied EBP. R5 was in the room attached to mechanical lift on the commode. NA-A and NA-B transferred R5 from the commode to the bed and removed the mechanical lift. NA-A wiped R5's bottom. Applied pants on R5's legs and incontinent product by rolling R5 side to side. Re-attached mechanical lift to R5. Transferred R5 to wheelchair and adjusted R5's shirt and boosted back in the wheelchair to R5's comfort. Gave R5 the call light and placed overhead table in front of wheelchair. Removed EBP and sanitized hands. R10 R10's face sheet dated 4/15/25, identified diagnoses of parkinsonism (difficulties with	F 880		

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F 880	Continued From page 20 movement). R10's care plan dated 2/17/25, identified R10 required extensive assistance with personal hygiene. During an observation on 4/10/25 at 7:06 a.m., R10 was laying in bed. NA-C filled water in a basin.Applied gloves. Asked R10 to remove dentures so they could be brushed, removed and put in container to soak during cares. Washed face and abdominal region with soap and water after removing gown. After drying R10, applied a shirt. Opened brief and cleansed peri area. Grabbed another washcloth and cleaned backside. Put on a new incontinent product. Removed gloves and put a new pair on. Put a few gloves in her pocket. Put pants on. Had R10 sit on the edge of bed, put on socks, put walker in front of him. Transferred to wheelchair. Removed gloves and sanitized hands. During an interview on 4/10/25 at 8:36 a.m., NA-B stated that handwashing is done between residents. During an interview on 4/10/25 at 9:45 a.m., NA-C stated handwashing is done in the morning, on breaks, if bowel movements are bad and messy, otherwise hand sanitizer after exiting rooms. NA-C was unaware about handwashing between removing and applying new gloves. During an interview on 4/10/25 at 9:53 a.m., NA-A stated handwashing is used after coming in contact with a resident or leaving the room. It should be done between glove changes, I forgot. During an interview on 4/10/25 at 2:35 p.m.,	F 880		

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F 880	Continued From page 21	F 880		

registered nurse (RN)-A stated hand sanitizing is done throughout the day, in between glove changes. Wash hands before and after cares.

During an interview on 4/11/25 at 9:47 a.m., licensed practical nurse (LPN)-A stated management monitors, teaches, and reinforces hand hygiene and the importance of handwashing between pericare.

During an interview on 4/10/25 at 12:20 p.m., registered nurse infection preventionist (IP)-A stated the staff should wash or sanitize hands after glove removal and should change gloves and sanitize or handwash after cleaning the peri area whether front or back. Staff should not clean bowels and use the same gloved hand or cleaning utensil to clean the front side.

During an interview on 4/10/25 at 2:53 p.m., director of nursing (DON) stated they [management] observe a ton of handwashing, applying and removing gloves that are a month or two old. Nothing good can come of improper peri care, it could lead to an infection. Hand washing and/or sanitizing should be done more often than it is apparently. We have been pushing staff to wash hands when removing gloves and use the sink, it is available in every room. If cleaning something dirty, remove gloves, wash/sanitize hands, put on new gloves, it is not worth it to cross-contaminate.

The facility policy Perineal Care dated 2/8/22, identified the procedure was to provide cleanliness to the resident, prevent infections and skin irritation. For a female resident wash perineal area, wiping front to back. Wash the rectal area wiping from the base of the labia towards and

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F 880	Continued From page 22 extending over the buttocks. For a male resident wash perineal area starting with urethra and working outward. Wash rectal area thoroughly including under the scrotum, the anus, and buttocks.	F 880		