DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 13, 2026

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

RE: CCN: 245596
Cycle Start Date: September 23, 2026

Dear Administrator:

On November 6, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

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November 13, 2026

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

Re: Reinspection Results
Event ID: 3C57DE-H2

Dear Administrator:

On November 6, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 23, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 9, 2026

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

RE: CCN: 245596
Cycle Start Date: September 23, 2026

Dear Administrator:

On September 23, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility 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.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 23, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 23, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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October 9, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 3C57DE-H1

Dear Administrator:

The above facility survey was completed on September 23, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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, Rapid Response
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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF WORTHINGTON	1307 SOUTH SHORE DRIVE , WORTHINGTON, Minnesota, 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
F0000	INITIAL COMMENTS On 9/22/26, and 9/23/26, 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: H55964302C (3207996), and H55964306C (3208073); with a deficiency cited at F686. 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.	F0000		10/29/2026
F0686 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.	F0686	R 2 had a new Braden assessment, wound treatments, wound documentation and care plan reviewed and updated as needed. R2 will have daily skin checks implemented and new areas identified will have immediate interventions initiated and will be reported to the MD and resident representative. All current residents with wounds will have their wound interventions reviewed and care plans reviewed and updated as needed. Future residents whose develop wounds will have treatments and interventions implemented utilizing the MD standing orders along with MD and resident representative notification. Licensed nurses and nurse aides will be in-serviced on the Pressure Ulcer Risk Assessment policy with emphasis on Skin Assessment item #2 that skin will be assessed weekly and more frequently as needed and the staff will monitor and perform routine skin inspections with daily care. Director of Nursing is responsible for compliance.	10/29/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

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F0686 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to timely identify the development of skin breakdown, implement effective interventions, monitor the development of, and initiate appropriate care plan interventions for pressure ulcer development for 1 of 3 residents reviewed for pressure ulcers. Findings include: R2's face sheet identified R2 had diagnoses of unspecified dementia, other sequelae of cerebral infarction, contracture of left and right knee, benign neoplasm of meninges, type 2 diabetes, and disorder of bone density and structure unspecified site. R2's comprehensive Minimum Data Set (MDS) dated 9/8/26, R2 had severe cognitive impairment. R2 had unclear speech, does not understand, and rarely/never understands verbal content. R2 had inattention and altered level of consciousness but did not have behaviors. R2 was dependent on staff for eating, hygiene, toileting, bathing, dressing, putting on/taking off footwear, rolling, chair/bed to chair transfers, and toilet transfer. R2 was always incontinent of bowel and bladder. R2 had a pressure injury, was at risk of developing pressure ulcers. R2 had a stage 4 pressure injury that was not present at admission/entry or re-entry. R2 had application of nonsurgical dressings to areas other than feet. R2's care plan dated 3/27/25, for impaired physical mobility. Interventions on 7/28/26, included: ensure R2 is in proper position for tasks. Has "Geri Chair" to help with positioning. Take extra precaution when transferring R2 due to contractures/injury to lower extremity. Protective cover placed on bilateral sides of wheelchair to prevent injury/skin breakdown. utilize pressure relieving devices on appropriate surfaces. R2's hospital admission history dated 7/8/26, identified left femur fracture, chronic contractures of lower extremities, difficult to examine the extremities due to the contractures. R2's physician order from hospital dated 7/10/26, identified left lower extremity splinting: left anterior knee spanning abundantly padded orthoplast splint	F0686	Continued from page 1 Audits on weekly wound assessments, skin treatments and care plan interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 10/29/2026	10/29/2026

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F0686 SS = D	Continued from page 2 with no Velcro straps but just Tubi grip or mesh tubular elastic every day and evening shift. R2's Treatment administration record identified the treatment was administered daily and included to remove daily and assess for redness/skin break down. There was no identified skin impairment documented prior to 8/13/26. R2's progress note dated 8/13/27, at 2:57 p.m., identified per physician orders nurse to remove padding/Tubi grip at least one time per day to check for any redness/skin breakdown. R2 had her leg relaxed and extended at a 45-degree angle, TED and padding removed. Noticed scant amount of blood on sheets. Assessed where blood was coming from, it was unable to be seen without pulling apart/slight moving knee out forward without causing any pain. Surrounding skin within normal limits, no redness. TED and padding did not have any blood on it. noticed to the back of knee to have an open wound. R2's Pressure ulcer/Injury Evaluation dated 8/13/26, identified left popliteal fossa new wound identified as a stage 2 pressure ulcer: partial-thickness skin loss with exposed dermis in-house acquired. Measurements were 1.84 centimeters (cm) length, 1.10 cm width, and 0.20 cm depth. No undermining or tunnelling. Wound bed was 40% granulation and 60% slough. Wound bed was pink or red, or bleeding. Peri-wound had dried up blood; edges appear flush with wound bed or as a sloping edge. Surrounding tissue was fragile. Type of exudate was identified as serosanguineous and "exudate -odor after cleansing". The wound treatment identified included generic wound cleanser, foam dressing, wrap with kerlix and secure with tape performed every two days and as needed. R2's progress note dated 8/13/26, at 4:23 p.m., identified Tubi grep in place to prevent skin to back of knee rubbing together and prevent moisture. Applied foam and kerlix with tape per standing orders. Attempt to offload knee pit (behind) with small hand towel rolled or rolled kerlix to decrease pressure. Check placement of wound dressing and offloading item. MD-A updated. R2's care plan was revised on 8/14/26 with interventions that directed monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length by width by depth), stage and weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, and type of tissue and exudate. Although the	F0686		10/29/2026

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F0686 SS = D	Continued from page 3 progress note included an intervention to use a small hand towel or rolled kerlix to offload pressure, it was not evident the intervention was added to the care plan. In review of R2's physician orders, although the wound evaluation and the progress note dated 8/13/26 identified and directed a wound treatment, R2's physician orders did not include a treatment order. The treatment administration record identified between 8/13/26 through 8/17/26, R2's wound dressing was only changed on 8/17/26, which was four days from discovery of wound. R2's progress note dated 8/15/26, identified nurse was unable to extend contracture for wound dressing/to assess. Review of R2's record did not identify the physician was notified and/or additional attempts were made to change the dressing. R2's progress note dated 8/17/26, identified R2's back of knee had deteriorated. MD-A updated and requested new orders for collagen, calcium, foam and kerlix. Care plan updated. Wound nurse practitioner (WNP)-A scheduled to see R2 on 8/18/26. In review of R2's record identified, although there was noted deterioration of the wound there was no indication of a comprehensive assessment had been completed nor evident the care plan was revised with pressure relieving interventions. R2's physician orders dated 8/18/26, identified left posterior knee-apply collagen, calcium alginate, cover with foam and kerlix. Over kerlix for extra protection use a small towel or rolled kerlix to help decrease pressure. R2's Wound Evaluation and Management Summary from WNP-A dated 8/18/26, identified initial evaluation of popliteal pressure ulcer due to bilateral lower contractures. Focused wound exam included pressure staged at 4. Healing potential was poor. Measurements were 2.0 cm X 6.5 cm X 0.4 cm. Moderate serous exudate with 100% slough. Agitation, grimacing noted with exam. Surgical excision debridement procedure performed to surgically excise 10.40 cm of devitalized tissue including slough, biofilm, and non-viable muscles level tissues were removed at a depth of 0.6 cm and healthy, bleeding tissue observed. As a result of the procedure, the non-viable tissue in the wound bed decreased from 100% to 20%. Hemostasis was achieved and clean dressing applied. New orders to cleanse with wound cleanser daily, skin prep, collagen powder, alginate calcium with silver; cover	F0686		10/29/2026

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F0686 SS = D	Continued from page 4 with ABD pad, roll with 4-inch (in) gauze stretch roll and tape. R2's care plan identified an additional intervention that was included six days after pressure ulcer identification on 8/19/26, that directed staff to evaluate skin for areas of blanching or redness. Contractures to bilateral lower extremities, apply pillow/or small blanket to offload pressure between legs as needed (PRN). Apply orthosplint as ordered. Hand rolls to both hands. R2's care plan was again revised on 8/24/26, which included a focus for wound management-left posterior knee; blister to left hip back; on enhanced barrier precautions (EBP) with interventions dated 8/25/26 (12 days after pressure identification) which included Administer treatments as ordered and monitor for effectiveness. Administer antibiotic as prescribed and monitor worsening signs/symptoms of infection. Notify primary care provider (PCP) and wound nurse of no improvement. Monitor dressing posterior left knee to ensure it is intact and adhering. Report loose dressing to Treatment nurse. Gray pillow larger to position calf away from back of thigh on left leg. R2's Wound Evaluation and Management Summary from WNP-A dated 8/24/26, identified stage 4 pressure ulcer had increased odor and drainage, depth increased, tendon was visible, redness of periwound visualized. Measurements were 2.0 cm X 7.0 cm X 1.7 cm. Heavy, serous exudate with 100% slough. One or more signs of clinical infection. Debridement attempted but aborted due to difficulty with pain management, difficult location due to contractures. Ultrasound mist became a safer and preferred modality. New orders to cleanse with wound cleanser, skin prep, hydrafera blue foam daily with ABD pad, gauze roll, and tape to secure dressing. R2's Wound Evaluation and Management Summary from WNP-A dated 9/1/26, identified wound measured 2.0 cm X 2.5 cm X 0.5 cm and wound progress improved evidenced by decreased depth, decreased infection, decreased necrotic tissue, and decreased surface area. New orders for Hydrafera blue foam three times daily covered with ABD and rolled gauze.	F0686		10/29/2026

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F0686 SS = D	Continued from page 5 During an interview on 9/23/26, at 2:31 p.m., RN-B stated she worked on 8/12/26, but could not recall what time she removed R2's splint and Tubi grip from the left leg on 8/12/26, but felt she would not have removed it until after 10 a.m. and did not see any skin impairment when she changed the dressing. During an interview on 9/23/26, at 2:04 p.m., registered nurse (RN)-A stated she worked on 8/13/26 and discovered the pressure ulcer to R2's popliteal. Licensed practical nurse (LPN)-A was orientating with her at the time of the discovery. RN-A stated she also worked on 8/11/26, and no wound was present when she removed the dressing that day. The order was scheduled for day shift and nurses could remove the splint and Tubi grip at any time during the shift. RN-A stated she normally removed the splint and Tubi grip around the end of her shift and had the evening shift reapply the splint and Tubi grip. On 8/13/26, RN-A noticed blood on the sheet when she removed the splint and Tubi grip. Assessed R2's skin and noticed a pressure ulcer. RN-A notified the director of nursing (DON), MD-A, and R2's family. During a phone interview on 9/23/26, at 2:50 p.m., LPN-A stated on 8/12/26 she orientated with RN-B and 8/13/26 she was in orientation with RN-A. LPN-A did not look at R2's leg on 8/12/26, however was with RN-A when the wound was discovered on 8/13/26. During an observation on 9/22/26, at 12:57 a.m., nursing assistant (NA)-A and NA-B assisted R2 to bed. NA-B stated R2 had a yellow cushion pad that she wore to protect her contracted knee with a sock over it because it had been getting irritated and red in the back of the knee area. NA-A thought the pressure ulcer behind R2's knee was from the sock she wore. NA-A and NA-B placed a pillow between R2's legs, a wedge under her side, and a pillow under her feet. During an interview on 9/23/26, at 7:35 a.m., registered nurse (RN)-A stated when R2 returned from the hospital on 7/10/26, she had a Tubi grip for protection and to keep moisture from accumulating behind the knee. Nurses were to do daily skin checks on the area and remove the padding and Tubi grip for a little bit and reapply. Before the left pressure ulcer occurred, RN-A stated "we" had noticed redness and were assessing the back of the leg however there was no documentation of noted assessments. RN-A did not identify what interventions were implemented to prevent or	F0686		10/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

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F0686 SS = D	Continued from page 6 decrease the redness. RN-A could not articulate when redness was noted and who “we” was. During an interview on 9/23/26, at 3:28 p.m., DON stated R2’s brace was foam and Tubi grip. Nurses were to monitor for breakdown of skin and signs of pain when they removed the treatments every day. DON explained R2 had contractures that made it difficult for nursing to see the skin behind the knee because the leg would have to be extended which would cause discomfort for R2. The wound would not have been visible if staff were not opening the knee and extending it and would have been “very hard to visualize”. DON thought it was plausible that nurses may have missed seeing the deterioration and also would not have wanted to cause pain to R2 by manipulating the knee to open to the extent to visualize the ulcer and seeing the blood made them look further into it. DON would have expected continued deterioration to the wound if it was unpreventable and described the wound as currently stable. During a phone interview on 9/23/26, at 8:08 a.m., WNP-A stated R2’s pressure ulcer behind her left knee was avoidable if appropriate assessments, monitoring, and interventions had been implemented and followed. During a phone interview on 9/23/26, MD-A stated he did not think a stage 4 pressure ulcer could form in one day. MD-A stated his understanding of R2’s pressure ulcer was that it had been forming for several weeks and was preventable. The facility Prevention of Pressure Injuries policy undated, identified the facility would review the residents care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable. Device related pressure injuries included review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, application, and ability to secure the device. Monitor regularly for comfort and signs of pressure-related injury. For prevention measures associated with specific devices, consult current clinical practice guidelines. Evaluate, report, and document potential changes in skin, review interventions and strategies for effectiveness on an ongoing basis.	F0686		10/29/2026

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20000	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 9/22/26, and 9/23/26, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55964302C (3207996), and H55964306C (3208073)with a licensing order issued at 0900.	20000		10/29/2026

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

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20000	Continued from page 1 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 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.	20000		10/29/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 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	20900	Corrected	10/29/2026

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20900	Continued from page 2 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to timely identify the development of skin breakdown, implement effective interventions, monitor the development of, and initiate appropriate care plan interventions for pressure ulcer development for 1 of 3 residents reviewed for pressure ulcers. Findings include: R2’s face sheet identified R2 had diagnoses of unspecified dementia, other sequelae of cerebral infarction, contracture of left and right knee, benign neoplasm of meninges, type 2 diabetes, and disorder of bone density and structure unspecified site. R2’s comprehensive Minimum Data Set (MDS) dated 9/8/26, R2 had severe cognitive impairment. R2 had unclear speech, does not understand, and rarely/never understands verbal content. R2 had inattention and altered level of consciousness but did not have behaviors. R2 was dependent on staff for eating, hygiene, toileting, bathing, dressing, putting on/taking off footwear, rolling, chair/bed to chair transfers, and toilet transfer. R2 was always incontinent of bowel and bladder. R2 had a pressure injury, was at risk of developing pressure ulcers. R2 had a stage 4 pressure injury that was not present at admission/entry or re-entry. R2 had application of nonsurgical dressings to areas other than feet. R2’s care plan dated 3/27/25, for impaired physical mobility. Interventions on 7/28/26, included: ensure R2 is in proper position for tasks. Has “Geri Chair” to help with positioning. Take extra precaution when transferring R2 due to contractures/injury to lower extremity. Protective cover placed on bilateral sides of wheelchair to prevent injury/skin breakdown. utilize pressure relieving devices on appropriate	20900		10/29/2026

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20900	Continued from page 3 surfaces. R2’s hospital admission history dated 7/8/26, identified left femur fracture, chronic contractures of lower extremities, difficult to examine the extremities due to the contractures. R2’s physician order from hospital dated 7/10/26, identified left lower extremity splinting: left anterior knee spanning abundantly padded orthoplast splint with no Velcro straps but just Tubi grip or mesh tubular elastic every day and evening shift. R2’s Treatment administration record identified the treatment was administered daily and included to remove daily and assess for redness/skin break down. There was no identified skin impairment documented prior to 8/13/26. R2’s progress note dated 8/13/27, at 2:57 p.m., identified per physician orders nurse to remove padding/Tubi grip at least one time per day to check for any redness/skin breakdown. R2 had her leg relaxed and extended at a 45-degree angle, TED and padding removed. Noticed scant amount of blood on sheets. Assessed where blood was coming from, it was unable to be seen without pulling apart/slight moving knee out forward without causing any pain. Surrounding skin within normal limits, no redness. TED and padding did not have any blood on it. noticed to the back of knee to have an open wound. R2’s Pressure ulcer/Injury Evaluation dated 8/13/26, identified left popliteal fossa new wound identified as a stage 2 pressure ulcer: partial-thickness skin loss with exposed dermis in-house acquired. Measurements were 1.84 centimeters (cm) length, 1.10 cm width, and 0.20 cm depth. No undermining or tunnelling. Wound bed was 40% granulation and 60% slough. Wound bed was pink or red, or bleeding. Peri-wound had dried up blood; edges appear flush with wound bed or as a sloping edge. Surrounding tissue was fragile. Type of exudate was identified as serosanguineous and “exudate -odor after cleansing”. The wound treatment identified included generic wound cleanser, foam dressing, wrap with kerlix and secure with tape performed every two days and as needed. R2’s progress note dated 8/13/26, at 4:23 p.m., identified Tubi grep in place to prevent skin to back of knee rubbing together and prevent moisture. Applied foam and kerlix with tape per standing orders. Attempt to offload knee pit (behind) with small hand towel rolled or rolled kerlix to decrease pressure. Check placement of wound dressing and	20900		10/29/2026

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20900	Continued from page 4 offloading item. MD-A updated. R2's care plan was revised on 8/14/26 with interventions that directed monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length by width by depth), stage and weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, and type of tissue and exudate. Although the progress note included an intervention to use a small hand towel or rolled kerlix to offload pressure, it was not evident the intervention was added to the care plan. In review of R2's physician orders, although the wound evaluation and the progress note dated 8/13/26 identified and directed a wound treatment, R2's physician orders did not include a treatment order. The treatment administration record identified between 8/13/26 through 8/17/26, R2's wound dressing was only changed on 8/17/26, which was four days from discovery of wound. R2's progress note dated 8/15/26, identified nurse was unable to extend contracture for wound dressing/to assess. Review of R2's record did not identify the physician was notified and/or additional attempts were made to change the dressing. R2's progress note dated 8/17/26, identified R2's back of knee had deteriorated. MD-A updated and requested new orders for collagen, calcium, foam and kerlix. Care plan updated. Wound nurse practitioner (WNP)-A scheduled to see R2 on 8/18/26. In review of R2's record identified, although there was noted deterioration of the wound there was no indication of a comprehensive assessment had been completed nor evident the care plan was revised with pressure relieving interventions. R2's physician orders dated 8/18/26, identified left posterior knee-apply collagen, calcium alginate, cover with foam and kerlix. Over kerlix for extra protection use a small towel or rolled kerlix to help decrease pressure. R2's Wound Evaluation and Management Summary from WNP-A dated 8/18/26, identified initial evaluation of popliteal pressure ulcer due to bilateral lower contractures. Focused wound exam included pressure staged at 4. Healing potential was poor. Measurements were 2.0 cm X 6.5 cm X 0.4 cm. Moderate serous exudate with 100% slough. Agitation, grimacing noted with exam. Surgical	20900		10/29/2026

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20900	Continued from page 5 excision debridement procedure performed to surgically excise 10.40 cm of devitalized tissue including slough, biofilm, and non-viable muscles level tissues were removed at a depth of 0.6 cm and healthy, bleeding tissue observed. As a result of the procedure, the non-viable tissue in the wound bed decreased from 100% to 20%. Hemostasis was achieved and clean dressing applied. New orders to cleanse with wound cleanser daily, skin prep, collagen powder, alginate calcium with silver; cover with ABD pad, roll with 4-inch (in) gauze stretch roll and tape. R2’s care plan identified an additional intervention that was included six days after pressure ulcer identification on 8/19/26, that directed staff to evaluate skin for areas of blanching or redness. Contractures to bilateral lower extremities, apply pillow/or small blanket to offload pressure between legs as needed (PRN). Apply orthosplint as ordered. Hand rolls to both hands. R2’s care plan was again revised on 8/24/26, which included a focus for wound management-left posterior knee; blister to left hip back; on enhanced barrier precautions (EBP) with interventions dated 8/25/26 (12 days after pressure identification) which included Administer treatments as ordered and monitor for effectiveness. Administer antibiotic as prescribed and monitor worsening signs/symptoms of infection. Notify primary care provider (PCP) and wound nurse of no improvement. Monitor dressing posterior left knee to ensure it is intact and adhering. Report loose dressing to Treatment nurse. Gray pillow larger to position calf away from back of thigh on left leg. R2’s Wound Evaluation and Management Summary from WNP-A dated 8/24/26, identified stage 4 pressure ulcer had increased odor and drainage, depth increased, tendon was visible, redness of periwound visualized. Measurements were 2.0 cm X 7.0 cm X 1.7 cm. Heavy, serous exudate with 100% slough. One or more signs of clinical infection. Debridement attempted but aborted due to difficulty with pain management, difficult location due to contractures. Ultrasound mist became a safer and preferred modality. New orders to cleanse with wound cleanser, skin prep, hydrafera blue foam daily with ABD pad, gauze roll, and tape to secure dressing.	20900		10/29/2026

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20900	Continued from page 6 R2’s Wound Evaluation and Management Summary from WNP-A dated 9/1/26, identified wound measured 2.0 cm X 2.5 cm X 0.5 cm and wound progress improved evidenced by decreased depth, decreased infection, decreased necrotic tissue, and decreased surface area. New orders for Hydrafera blue foam three times daily covered with ABD and rolled gauze. During an interview on 9/23/26, at 2:31 p.m., RN-B stated she worked on 8/12/26, but could not recall what time she removed R2’s splint and Tubi grip from the left leg on 8/12/26, but felt she would not have removed it until after 10 a.m. and did not see any skin impairment when she changed the dressing. During an interview on 9/23/26, at 2:04 p.m., registered nurse (RN)-A stated she worked on 8/13/26 and discovered the pressure ulcer to R2’s popliteal. Licensed practical nurse (LPN)-A was orientating with her at the time of the discovery. RN-A stated she also worked on 8/11/26, and no wound was present when she removed the dressing that day. The order was scheduled for day shift and nurses could remove the splint and Tubi grip at any time during the shift. RN-A stated she normally removed the splint and Tubi grip around the end of her shift and had the evening shift reapply the splint and Tubi grip. On 8/13/26, RN-A noticed blood on the sheet when she removed the splint and Tubi grip. Assessed R2’s skin and noticed a pressure ulcer. RN-A notified the director of nursing (DON), MD-A, and R2’s family. During a phone interview on 9/23/26, at 2:50 p.m., LPN-A stated on 8/12/26 she orientated with RN-B and 8/13/26 she was in orientation with RN-A. LPN-A did not look at R2’s leg on 8/12/26, however was with RN-A when the wound was discovered on 8/13/26. During an observation on 9/22/26, at 12:57 a.m., nursing assistant (NA)-A and NA-B assisted R2 to bed. NA-B stated R2 had a yellow cushion pad that she wore to protect her contracted knee with a sock over it because it had been getting irritated and red in the back of the knee area. NA-A thought the pressure ulcer behind R2’s knee was from the sock she wore. NA-A and NA-B placed a pillow between R2’s legs, a wedge under her side, and a pillow under her feet. During an interview on 9/23/26, at 7:35 a.m., registered nurse (RN)-A stated when R2 returned	20900		10/29/2026

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20900	Continued from page 7 from the hospital on 7/10/26, she had a Tubi grip for protection and to keep moisture from accumulating behind the knee. Nurses were to do daily skin checks on the area and remove the padding and Tubi grip for a little bit and reapply. Before the left pressure ulcer occurred, RN-A stated “we” had noticed redness and were assessing the back of the leg however there was no documentation of noted assessments. RN-A did not identify what interventions were implemented to prevent or decrease the redness. RN-A could not articulate when redness was noted and who “we” was. During an interview on 9/23/26, at 3:28 p.m., DON stated R2’s brace was foam and Tubi grip. Nurses were to monitor for breakdown of skin and signs of pain when they removed the treatments every day. DON explained R2 had contractures that made it difficult for nursing to see the skin behind the knee because the leg would have to be extended which would cause discomfort for R2. The wound would not have been visible if staff were not opening the knee and extending it and would have been “very hard to visualize”. DON thought it was plausible that nurses may have missed seeing the deterioration and also would not have wanted to cause pain to R2 by manipulating the knee to open to the extent to visualize the ulcer and seeing the blood made them look further into it. DON would have expected continued deterioration to the wound if it was unpreventable and described the wound as currently stable. During a phone interview on 9/23/26, at 8:08 a.m., WNP-A stated R2’s pressure ulcer behind her left knee was avoidable if appropriate assessments, monitoring, and interventions had been implemented and followed. During a phone interview on 9/23/26, MD-A stated he did not think a stage 4 pressure ulcer could form in one day. MD-A stated his understanding of R2’s pressure ulcer was that it had been forming for several weeks and was preventable. The facility Prevention of Pressure Injuries policy undated, identified the facility would review the residents care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable. Device related pressure injuries included review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, application, and ability to secure the device. Monitor regularly for comfort and signs of pressure-related injury. For prevention measures associated with specific	20900		10/29/2026

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20900	Continued from page 8 devices, consult current clinical practice guidelines. Evaluate, report, and document potential changes in skin, review interventions and strategies for effectiveness on an ongoing basis. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		10/29/2026