DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1LIK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00917

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245376**
2.STATE VENDOR OR MEDICAID NO.
(L2) **766119300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ZUMBROTA CARE CENTER**
(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN** (L6) **55992**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**

6. DATE OF SURVEY 10/17/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective October 9, 2013, the facility is certified for 42 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 11/1/13 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5376 December 26, 2013

Mr. Scott Jackson, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, Minnesota 55992

Dear Mr. Jackson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 9, 2013, the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 1, 2013

Mr. Scott Jackson, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, Minnesota 55992

RE: Project Number S5376022

Dear Mr. Jackson:

On September 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 23, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 17, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 23, 2013, effective October 9, 2013 and therefore remedies outlined in our letter to you dated September 11, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245376	A. Building B. Wing	10/17/2013

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2013**
ID Prefix **F0327** Reg. # **483.25(i)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/30/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/30/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/30/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GN/AK	**Date:** 11/01/2013	**Signature of Surveyor:** 10160	**Date:** 10/17/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/23/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Complaint tags issued

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245376	A. Building B. Wing	10/17/2013

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/30/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/30/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GN/AK	**Date:** 11/01/2013	**Signature of Surveyor:** 10160	**Date:** 10/17/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/23/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245376	A. Building B. Wing 01 - MAIN BUILDING 01	10/21/2013

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/18/2013	ID Prefix Reg. # NFPA 101 LSC K0071	09/12/2013	ID Prefix Reg. # NFPA 101 LSC K0072	10/09/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/AK	Date: 11/01/2013	Signature of Surveyor: 25822	Date: 10/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/21/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1LIK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00917

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245376**
2.STATE VENDOR OR MEDICAID NO.
(L2) **766119300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ZUMBROTA CARE CENTER**
(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN** (L6) **55992**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**

6. DATE OF SURVEY **08/23/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 09/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/21/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed August 23, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7029

September 11, 2013

Ms. Shannon Donahue, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: Project Number S5376022

Dear Ms. Donahue:

On August 23, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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. In addition, at the time of the August 23, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5376008.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-271

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 23, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 23, 2014 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation/s had been completed at the time of the standard recertification survey. Investigation/s of complaint H5376008 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F323 and F353.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop an initial care plan interventions based on the residents health needs at the time of admission and before the comprehensive care plan is developed 21 days after admission for 2 of 18 residents (R60 and R57) who were admitted less then 21 days ago and had medical needs identified but not care planed.	F 281	ZHS will provide services that meet professional standards of quality. R60s CP was updated to include history of bruises acquired at home from a fall out of bed and missing tooth. R57's Care Plan was updated with complete renal dialysis care information. All new admissions with ESRD will be audited by DON/designee to ensure the 24hr Care Plan includes all pertinent renal dialysis care information. Appropriate Nursing staff were re-educated on the pertinent information and the time frames for Care Plan completion on 9/20/13. All resident Care Plans will be audited by DON/designee to ensure all pertinent information is included on the 24 hr Care Plan, and the comprehensive Care Plan is completed by day 21 after admission. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 9/30/13	9/30/13

9-23-13 JPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Daniel — TITLE: Administrator — (X6) DATE: 9/21/13

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 281	Continued From page 1 Findings include: R60's initial care plan had not addressed skin issues, dental issues, and falls. R60 was admitted to the facility on 7/23/13, with diagnoses that included but were not limited to: hypertension, diabetes, degenerative disc disease, and heart disease. During observation and interview of R60, on 8/20/2013 at 10:25 a.m., a large dark purple bruised area was observed on the upper left arm, a large dark purple bruise on the right outer arm near wrist area and a small purple bruise on the left forearm. R60 stated, "I fell out of bed at home and got the bruises from that." Also observed during the interview, R60 had a missing tooth on the left upper front area. The resident stated it had been missing for over a year. During review of the current care plan, with print date of 7/25/13, it was noted the care plan had not addressed R60's skin issues, dental issues, or falls. The certified nurse aide "to do list report" identified monitoring of blood pressure, ace wraps and diet. The care assignment for the nurse aides identified R60 required an assist of one for transfers, repositioning/off-loading buttocks every two hours, and ADL's (activities of daily living). The care assignment also identified R60 used a side rail and thigh high teds socks. On 8/19/13 at 1:15 p.m., the director of nursing (DON) was interviewed regarding care plans. She stated the most up-to-date care plans were in a binder and this one was given to the surveyor.	F 281		

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F 281	Continued From page 2 On 8/23/2013 at 9:00 a.m., the DON and registered nurse (RN) consultant were interviewed regarding R60's initial care plan. The RN consultant indicated she did not think there was anything wrong with the care plan. They considered the care assignment sheets for nursing assistants as the care guides for nursing assistants and considered it as part of their care plan. The working care plan was just that (the care assignment sheets). The more complete care plan is in the computer and is done by the Minimum Data Set (MDS) nurse. R57's initial care plan lacked staff instructions for body location of the dialysis access site, the care of the access site, which extremity to avoid for blood pressures, the signs and symptoms of infection, requirements for checking the access site bruit and thrill, and dialysis related emergency care directions. R57 was admitted to the facility 8/16/13, with diagnosis that included end stage renal disease and dialysis. During observations on 8/19/13, at 5:30 p.m., R57 ate supper in her room. Observations at that time revealed a half glass of water on her tray table. R57 stated she could have as much water to drink as she wanted. R57 stated she received a special diet and knew what she could and could not eat. R57 revealed the dialysis access site located in her upper left arm, a very large, protruding area with no dressing. Observations at that time revealed large areas of dark purple discoloration on both arms. R57 stated she received dialysis three times a week. R57 stated the facility staff removed the left arm dialysis dressing the morning after dialysis.	F 281		

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F 281	Continued From page 3 R57's initial care plan, dated 8/13 (day of admission), directed R57 received a renal diet with a 1.5 Liter fluid restriction and received dialysis three times weekly. The care plan had no other staff instructions related to renal disease or dialysis treatments. Document review of nursing notes dated 8/16/13, revealed numerous areas of bruising noted to R57's upper extremities and large bruise over her left inner arm fistula. R57 was identified as alert and oriented. Document review of the facility medication administration record revealed a lack of dialysis care instructions. Document review of nursing "to do list" revealed instructions to check R57's access site for bruit (unusual sound that blood makes when in rushes past an obstruction) and thrill (vibration felt by the examiner or palpation.) During interview on 8/22/13, at 8:10 a.m., LPN-A stated if bleeding at the access site were to occur, she would notify the charge nurse and apply pressure. LPN-A stated R57 was on a fluid restriction, had dialysis Tuesday/ Thursday/ Saturday, and nursing checked the access site for bruit and thrill, which was on the nursing "to do list." During interview on 8/22/13, at 1:00 p.m., DON verified the initial care plan lacked a complete listing of instructions for a dialysis resident. DON stated she expected the dialysis care instructions to be located on the facility medication administration record and on the nurses to do list. She verified the medication record lacked any	F 281		

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F 281 F 318 SS=D	Continued From page 4 dialysis care instructions. She verified the to do list included only the checking of bruit and thrill. 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing rehabilitative services as ordered for 1 of 2 residents (R1) reviewed for rehabilitative services to maintain or increase range of motion (ROM.) Findings include: R1 was admitted to the facility 12/11/2012, the admission data base indicated diagnoses of multiple sclerosis (a progressive disease of the central nervous system (brain, spinal cord, and optic nerve) causing progressive loss of muscle tone and loss of eye sight by disrupting the signals from the central nervous system to the muscles of the body, which can result in functional quadriplegia.) A quarterly Minimum Data Set (MDS) dated 6/17/13, indicated a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated no cognitive impairment. Had a mood score of 15	F 281 F 318	F318: ZHS provides appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. R1 had a decline in her ROM after an exacerbation of her Multiple Sclerosis for which she was hospitalized from 6/6/13 to 6/10/13. The resident has had an increase in her abilities to use her UEs since her return to the facility. R1's PROM Restorative program was reviewed and revised to fit the resident's preferences and abilities on 9/12/13. R1's PROM results will be documented by the RN Restorative Coordinator on a weekly basis to determine the resident's pattern of refusing her PROM. A Restorative summary was completed for this resident on 9/12/13. Random audits of residents receiving PROM will be conducted by DON/designee, 2 X week X 2, then weekly thereafter to ensure programs are being followed per Restorative Care Plan. Restorative Aide will continue to assist with resident cares as scheduled for 2 hrs in the morning, and then will perform Restorative duties for the remainder of the shift. Audit results will be brought to the QAPI committee for review and any further recommendations. Completion date: 9/30/13	9/30/13

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F 318	Continued From page 5 which indicated R1 had trouble concentrating and little interest or pleasure in doing things almost every day. R1 required total assist of two staff for bed mobility, transfers, and toileting. R1 required a total assist of one staff for personal hygiene, locomotion on and off the unit, and extensive assistance of one for dressing and eating. R1 was assessed by physical therapy (PT) on 12/11/12, and noted to have full range of motion in all joints, but was spastic (stiff muscles and exaggerated reflexes) in her bilateral lower extremities and right hand. Her right shoulder motion is only to 90 flexion but it is functional for her. R1 had orders to receive range of motion (ROM) to bilateral upper and lower extremities every day. During a stage one interview R1 stated they did not have enough staff to care for the residents because she did not always receive her ROM exercises, and they were not always able to lie her down in bed at 7:30 p.m. as was her preference. On 8/21/13 at 8:52 a.m. R1 stated, "They are always short staffed, this is the hardest wing to work on, and they can't keep employees." She continued to say "When state is here everyone is out helping, that doesn't happen when state is not here. There are never enough feeders [staff who assist resident to eat] in the little dining room, I tell them to dish me up last and cover my food to keep it warm until someone can sit with me, I don't mind waiting to eat, but I want my food warm when I eat it." A review of R1's ROM logs indicated she did not receive, or received only a portion of her ROM for 19 out of 30 days in June 2013 (received partial on four days), 14 out of 31 days in July 2013	F 318		

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F 318	Continued From page 6 (received partial on one day), and 9 out of 22 days in August 2013 (received partial on one day). R1 was refusing the left upper extremity active ROM, because she uses that arm and hand extensively. The ROM log indicated on 5/16/13 the restorative aide was pulled to the floor to cover for a nursing assistant meeting; on 8/7/13, the note indicated a lack of time due to helping out on the floor; on 8/15/13 the ROM notes indicated floor (working on the floor as a NA). R1 occasionally refused ROM with the right hand because it was causing her pain. The right hand 1st and 2nd fingers are spastic and were in a hyperflexed (Flexion of a limb or part beyond its normal range) position. R1 received Baclofen 40 mg four times a day (a muscle relaxer) and methocarbamol (muscle relaxant) 750 mg three times a day. On 8/22/13, at 1:38 p.m. the administrator was requested to attend the ROM measurement for R1 which was completed by physical therapist (PT)-1. The left ankle was noted at minus 10 degrees. The right ankle did not reach neutral and caused the resident an uncomfortable feeling. "I feel pressure, I do not like how your treating it " The right elbow was able to only reach 70 degrees flexion, the right shoulder at 70 flexion and the resident complained of "new palm and finger pins and needles", the right shoulder was only able to reach 50 degrees adduction and was "quite tight" the resident refused supination of right wrist. The right hand had the first two digits hyperextended and the resident was not able to make a fist. PT-1 verified that this was a decline in ROM for the resident in the left ankle, right shoulder, right elbow and right hand. The care plan dated 12/11/12, indicated restorative nursing. had a goal dated 6/20/13, "the resident	F 318		

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F 318	Continued From page 7 will not decline in ROM abilities by participating in restorative program as evidenced by (AEB) being able to cross legs with staff assistance x 92 days." On 5/31/13 offer a cold pack to hand prior to PROM. The interventions list Resident is on a restorative program see restorative program POC, approved 4/26/13. The restorative program plan of care was requested and not provided by the facility. A care area assessment (CAA) summary was requested and not provided by the facility.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to prevent falls for 3 of 16 residents (R49, R26, and R6) who were reviewed to have multiple falls in the past three months. Findings include: R49 was admitted with cerebral vascular accident (stroke), vascular dementia, urine retention, and gait abnormality (difficulty walking). The Minimum Data Set (MDS) a comprehensive	F 323		

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F 323	Continued From page 8 assessment dated 5/14/13 recorded R49 had moderate cognitive impairment, required extensive assistance of one person for dressing and limited assistance of one person for bed mobility, transferring, walking in room and corridor, ambulation on and off the unit, toileting and personal hygiene, and supervision with eating. R49 had a urinary catheter in place for obstruction. R49 had a history of confusion, refusal of cares, and striking out at staff; and was to be redirected from inappropriate behavior, removed from situations, and re-oriented by using a snack, a drink, or a walk and have stimulation decreased. To be observed for verbal aggression, physical aggression, resistance, refusal of cares and pain; and have the call bell within reach. A restorative nursing care plan dated 5/13/13 directed ambulation twice a day and upper extremity (UE) and lower extremity (LE) exercises, supervision and cues for am grooming and hygiene. On 8/15/13, a functional maintenance program was added to the restorative care plan, staff to provide supervision/verbal cures or assist of one with dressing and grooming tasks a.m. and p.m. A transferring care plan indicated stand by assistance of one with a transfer belt and walker. A CAA summary indicated a high fall risk. Bed and chair alarm in place and functioning properly, motion sensor in place at edge of bed to alert staff of resident sitting up in bed. It was learned that R49 fell eleven times during a three month period. The care plan lacked direction to keep the residents wheelchair and belongings within reach. R49 fell on 6/23/13, at 10:20 a.m. and was found	F 323	F323: ZHS provides care and services to prevent falls as identified by the Falls Risk Assessment, Falls Scene Investigation, including a root cause analysis after a fall and tracking and trending of falls. R49's Care Plan was reviewed and revised to include direction to keep the wheelchair and belongings within reach. A Root Cause Analysis and Summary of R49's falls was completed on 9/2/13 and the Care Plan was updated as per assessment findings. A Root Cause Analysis and Summary of R26's falls was completed on 9/19/13 , and the Care Plan was updated as per assessment findings. A Root Cause Analysis and Summary of R6's falls was completed on 8/30/13 and the Care Plan was updated as per assessment findings. R6 had had a Restraint Assessment completed when removed the remote control for the recliner, on 7/23/13, and it was determined that the resident was unable to get up or transfer from the chair even if sitting upright, so would not be considered a restraint. Nursing staff were re-educated on the facility's Falls protocol on 9/19/13. After any fall, a resident with anti-rollback devise on wheelchair will be checked for proper functioning.	

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F 323	Continued From page 9 crawling on his knees, and reported he had gotten from the wheelchair to the recliner and then stood from the recliner to get into the bed. Resident did not have the walker next to the recliner so he tried to use the bedside table for balance to get into bed and lost his balance, the call light was within reach and his slippers were on. The immediate intervention was monitoring and other (with no description of other). The facility census was 34 and staff hours had been flexed down. The DON identified this was a weekend and no restorative aide was scheduled, and a staff who was ill had not been replaced. On 7/3/13, at 11:00 a.m. R49 fell attempting to self-transfer from bed to wheelchair, the alarm did sound, the wheelchair has auto-lock brakes, the call light was within reach, the alarm was on, the fall matt was on the floor and the resident was wearing slipper. The immediate intervention was monitoring. The facility census was 33 and the staff had been reduced due to low census. On 7/3/13, at 5:50 p.m. it was noted R49 ' s door was closed, resident was found on the floor lying next to the TV stand/dresser. Resident denied hitting head on TV stand but stated he had hit head on the floor. Resident stated he was in the wheelchair and it tipped over, but the wheelchair and walker were sitting next to the bed and both were upright. Laceration over the right eye, transported to the hospital for evaluation and treatment. The call light was within reach, the fall matt was on the floor, and slippers were on his feet. The immediate intervention was sent to emergency. On 7/5/13, at 8:10 p.m. R49 was heard to call for help. He was found lying on the floor next to this wheelchair. R49 stated, "I was just trying to get up" at the time of the fall safety checks were in place and the resident had slippers on. The root	F 323	F323 cont... On 9/2/13, Nursing staff were supplied with Walkie Talkies for use to notify other staff of need for assistance. Staffing on units is being reviewed and revised prn, as census changes, to ensure direct care staff is appropriately assigned per resident care needs. Tracking and trending of falls and use of additional interventions will be brought forward to QAPI committee for review and further recommendations. Completion date: 9/30/13	9/30/13

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F 323	Continued From page 10 cause of the fall was determined to be mood or mental status. The resident was re-educated on the importance of calling for assistance prior to attempting to self-transfer or ambulate. Bed was placed in low position and alarm checked. The immediate intervention was monitoring. On 7/9/13, at 12:30 p.m. R49's wheelchair alarm was not on and the resident fell in the bathroom, this was reported because the care plan was not followed. The incident report describes autolock brakes on the wheelchair; call light within reach, alarm in place, bed in low position and nonskid socks. The immediate intervention was monitoring and monitoring vital signs. The facility census was 33 and the staff had been flexed down and the restorative aide had been pulled to floor staff. On 7/12/12, at 12:58 a.m. R49's bed alarm was sounding and the resident was found sitting on the floor next to the bed. The resident has a bed alarm, chair alarm, call don't fall posters; call light and urinal within reach. The root cause was determined to be the amount of assistance in effect, the medical status, toileting status and mood or mental status. The immediate intervention was 30 minutes checks monitoring and vital signs monitoring. The facility census was 34 and the staff had been flexed down and the HUC/aide had been pulled to floor staff. On 7/15/13, at 7:35 p.m. R49 was found in the middle of the room on the floor, just past the floor mat, propped up on the right elbow, the resident had slippers on that did not have grippers, the call light was within reach, the alarm was on and the matt was next to the bed. The resident stated he was going to his wheelchair which was sitting next to the first bed in the room. The immediate intervention was safety checks monitoring and changed to gripper socks. The DON indicated	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 323	Continued From page 11 this was not reported because the care plan was followed and stated the intervention was to Velcro the bed control to the head of bed. The facility census was 34 and the staff had been flexed down On 8/14/13, at 8:15 p.m. R49 was found on hallway floor in front of room 112, the w/c pressure alarm was sounding. A visitor witnessed the resident who was sitting far forward in his wheelchair, the wheelchair had anti-rollback bars, and the resident had been reposition twice during the shift had but refused to lie down. The immediate intervention was safety checks monitoring vital signs. A message was left for therapy related to evaluation for a new wheelchair. The facility census was 36 and the staff had been flexed down. On 8/15/13, at 4:00 a.m. R49 was found scooting across the floor and R49 said "got out of bed to go over there " pointed to door of room. The resident had been awake and in his bed resting peacefully for most of the night. Resident kept removing all of his clothing, bed linens and brief during the night. Resident required three bed linen changes prior to the fall due to urinating onto linens. The root cause was determined to be the amount of assistance in effect, the alarm, the footwear, the medical status and the mood or mental status. The immediate intervention was to replace the silent bed alarm that had not sounded. The resident sounding sensor had also not working, replaced batteries and it continued not to function, the sensor was removed from the resident room and brought to the nurses ' station for repair, safety checks, and vital signs monitored. The facility census was 36 and the staff had a no call/no show NA and flexed hours. On 8/17/13, at 3:50 p.m. the R49 was found on the floor in room 111 and had been incontinent,	F 323		

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F 323	Continued From page 12 the chair alarm was not sounding. R49 stated, "I was trying to get into bed by myself." R49's wheelchair was behind him with the anti-rollback bars engaged, but the wheelchair breaks were not engaged and chair alarm was not turned on. R49 sustained a small bruise 0.25 centimeters (cm) to the left elbow. The immediate intervention was to check the chair alarm every hour for 24 hours. The facility census was 36 and the staff had been flexed down. On 8/19/13, at 7:00 a.m. R49 was found on the floor next to the bed and leaning right. R49 was not wearing any clothing and had been incontinent of bowel, the incontinent product was on the foot of the bed, and the bed alarm was sounding. The immediate intervention was safety checks, monitoring vital signs and neurological checks (assessing for trauma to the head). The root cause was determined to be toileting needs. R26 was admitted with diagnoses of hypothyroidism, dementia, Parkinson's disease (a progressive movement disorder that causes muscle rigidity, tremors, and changes in speech and gait), anxiety, chronic pain and hypotension (low blood pressure). The MDS dated 5/14/13, revealed R26 had intact cognition. R26 required extensive assistance of two for transferring and ambulation in the corridor. Extensive assistance of one for bed mobility, dressing and personal hygiene and toileting. Limited assistance for locomotion off the unit and set up only for eating. R26's care plan indicates attention seeking behaviors with anxiety, health complaints, and insomnia. R26 had a history of falls and has a bed alarm sensor pad that should be replaced every 30 days, a chair alarm, a high/low bed, and	F 323		

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F 323	Continued From page 13 should have the call light within reach. R26 uses a manual wheelchair and was encouraged to self-propel. On 7/8/13, at 7:40 p.m. R26 was found lying on the floor with upper body (head, neck and shoulder) on chair in room. Stated she moved self to this position to attempt to get herself up. She had been getting clothes out for bed, pajamas on chair near resident) and had slipped from wheelchair to the floor. The wheelchair does have anti-rollback brakes, but can still move a small distance. The immediate intervention was monitoring, monitoring vital signs and to hang a call don't fall sign in clear view in the resident room. The report did not indicate if the anti-rollback lock device was checked for proper functioning. On 7/22/13, at 12:15 p.m. R26 was found by staff on the floor next to the bed and had hit her head, the bed alarm was sounding. R26 thinks "she was reaching for something." The immediate intervention was monitoring vital signs, and neurological checks. The director of nursing (DON) noted intervention to re-evaluate the toileting plan and re-evaluate the risk/benefit of continued independence with wheelchair. On 8/10/13, at 3:20 p.m. R26's call light was on and the chair alarm was sounding, resident was found on the floor and stated she had to go to the bathroom. and was unable to wait any longer because of the Mirilax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) and attempted to self-transfer, as she transferred self R26 fell back and to her right side and noted to have a goose egg on the right side of her head. The immediate intervention was vital signs, neurological checks and an ice pack applied directly and wrapped in place. The root cause	F 323		

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F 323	Continued From page 14 was determined to be toileting status, the NA stated the resident had been toileted at 2:40 p.m. had been incontinent and urinated on the toilet, the call light was on, but the NA was with another resident. R6 was admitted to the facility on 1/30/2010, the admission data base indicated diagnoses of pre-senile depression, insomnia, chronic ischemic heart disease, chronic kidney disease, spinal stenosis, and history fall with osteoarthrosis (Osteoarthrosis is another name for the chronic condition known as osteoarthritis) of the left leg. The quarterly MDS assessment dated 7/24/13 indicated intact cognitive functioning. R6 required total assist of two staff and a mechanical lift or mechanical stand device for all transfers and repositioning, extensive assist of two staff for bed mobility, personal hygiene and toileting, extensive assistance of one staff for dressing, eating, and locomotion on and off the unit. R6 had impairment on one side in the upper extremities and both sides in the lower extremities were unsteady and only able to stabilize with human assistance, and used a wheelchair for transportation. The ambulation care plan dated 7/18/12 indicated R6 was non-ambulatory and was expected to be up in the wheelchair three times a day. R6 was cognitively intact, and had behavioral issues of refusal of cares, calling out, and negative statements. R6 was observed for behaviors of inappropriate call light use, refusal of cares, sadness and depression, staff was directed to re-approach as needed for refusal of cares. The safety care plan was updated 6/28/13 with a rock and go wheelchair, ½ side rail on the right side, and to keep the call light within reach. On 6/20/13 at 9:30 a.m. Incident Report Quick	F 323		

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F 323	Continued From page 15 Review form indicated the staff was " preparing " R6 to transfer to his recliner chair. "Staff was pushing R6 backwards in his wheelchair to make room for the Hoyer lift when the wheelchair started to tip backwards and could not be stopped. R6 fell back on the floor still seated in the wheelchair." "The NA [nursing assistant] was noted to be coming down the hall with one shoe off, to retrieve nurse for assistance and stated everything happened so fast, it was just a blur. Staff was preparing resident to transfer into recliner using the Hoyer lift. " The re-enactment stated, " Staff was pushing resident in wheelchair backwards to make room to get the Hoyer sling under him, when he began to tip backward. Staff attempted to catch resident, but was unable to intercept fall. Staffs shoe got caught in wheelchair when it fell off." Immediate interventions were safety checks, monitoring, monitoring vital signs, neurological checks, repair/replacement of equipment (anti-tip bars added to wheelchair. The incident was considered not reportable because the care plan was followed and there was no significant injury. The incident report lacked evidence of two staff in attendance during the incident, only one nursing assistant was listed as a witness, and only one statement was included in the witness statements. The statement indicates that the staff that was present during the fall, then left the resident alone (tipped backward in the wheelchair on the floor) and went to retrieve the nurse for assistance. A second incident quick report for 6/20/13 that recounted the same incident read "the staff was preparing resident for transfer, was not performing the transfer. " The root cause analysis progress note indicated R6 had a history of self-adjusting the recliner and chair, the family understands risks and benefits and want R6 as	F 323		

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F 323	Continued From page 16 mobile but safe as possible. The intervention was anti-rollbacks installed immediately, occupational therapy (OT) evaluation for wheelchair positioning. The facility census was 37 and staffed had been flexed down. On 8/23/13, at 2:45 p.m. an Incident Report Quick Review form indicated R6 was yelling out from his room, R6 was noted on the floor alongside the recliner. R6 stated he had pushed the recliner remote attempting to get the chair to recline backward more, but went in the wrong direction and slide out of the recliner. R6 sustained a 5 centimeter (cm) skin tear on the left arm, " just down from the elbow", which was cleansed and steri-stripped. The immediate intervention was dressing applied and neurological checks. The intervention noted by the DON was to Velcro the recliner remote to the wall (out of residents view or reach). On 8/22/13, at 10:30 a.m. during the environmental tour a section of paint had been removed behind the recliner, the environmental services director stated the recliner remote had been affixed to the wall out of the residents reach and had since been pulled off the wall taking the paint with it. The chart lacked evidence of an indication for, assessment for or orders for a restraint. Census sheets and staffing sheets were requested for 8/23/13, were requested and not provided.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced	F 327		

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F 327	Continued From page 17 by: Based on observation, interview and document review, the facility failed to ensure fluid intake monitoring for 1 of 1 resident (R57) reviewed with critical fluid restrictions due to renal disease and dialysis. Findings include: R57 was admitted to the facility with diagnoses that included end stage renal disease and dialysis. During observation and interview on 8/19/13, at 5:30 p.m., R57 ate supper in her room. Observations at that time revealed a half glass of water on her tray table. R57 stated she could have as much water to drink as she wanted. R57 stated she received a special diet and knew what she could and could not eat. R57 stated she received dialysis three times a week. During meal observation on 8/21/13, at 11:25 a.m., R57 ate jello and had 240 cubic centimeters (cc) of cranberry juice and 240 cc of water. Observations on 8/23/13, at 10:55 a.m. revealed a full pitcher of water and an empty glass located on R57's bedside stand, a half glass of cranberry juice and an empty can of Nepro supplement (Nepro Liquid Nutrition in Homemade Vanilla is intended for people requiring electrolyte and fluid restrictions) on her room table. Document review of the facility Nutrition Questionnaire, an assessment dated 8/21/13, identified R57 was on a renal diet, 1200 cc fluid restriction, diet was appropriate, and she ate independently.	F 327	F327: ZHS will ensure fluid intake monitoring will be documented and reviewed for resident with a fluid restriction. Nsg staff were re-educated on 9/20/13 regarding complete process for monitoring fluid intake for a resident with a fluid restriction. R57's fluid intake is documented every shift by Dietary at meals, by the Nurse during the medication pass and direct care staff for fluid in the resident's room. The total fluid intake amount is totaled at the end of the day by Nursing staff. Random audits will be conducted of daily documentation of fluid Intake by DON/designee, 4X week X 2 weeks, then 2X week X 2, then weekly thereafter. Audit results will be brought to QAPI committee for review and further recommendations. Completion date: 9/30/13	9/30/13

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F 327	Continued From page 18 Document review of the facility Hydration Questionnaire, an assessment dated 8/21/13; identified R57 required fluid restrictions and had an average fluid intake of 1001-1500 cc per day. R57 ' s initial care plan dated 8/13 (vs. the comprehensive care plan to be developed by the 21 day after admission), directed R57 received a renal diet, 1.5 Liter fluid restriction, and received dialysis three times weekly. The care plan had no other staff instructions related to renal disease or dialysis. Document review of nutrition note dated 8/16/13, revealed R57 received a general diet, required a 1500 cc fluid restriction, and she requested 240 cc of cranberry juice each meal and a Nepro supplement. During interview on 8/21/13, at 3:15 p.m., dietary director verified R57 required a 1500 cc fluid restriction. The dietary director identified the following fluid schedule for R57: 240 cc per meal, one can of Nepro supplement one time daily, 240 cc extra in the morning and 240 cc extra in the afternoon, with 60 cc of free fluids, as resident requests. The dietary director verified this was a total of 1440 cc, plus the 60 cc of free fluids, for a total of 1500 cc of fluid restriction for a 24 hour day. When asked who monitored R57's 24-hour fluid intake totals, the dietary director stated nursing department as the dietary department did not monitor total fluid intake. Dietary director stated all fluid intakes were recorded on the facility computerized charting system. During interview on 8/21/13 at 3:20 p.m., director of nursing (DON) stated dietary was responsible	F 327		

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F 327	Continued From page 19 to monitor 24-hour fluid intake totals. Document review of the facility dietary Monitoring Assessments Report revealed the following total fluid intake monitoring for the following dates: 8/16/13 was 480 cc 8/17/13 was 720 cc 8/18/13 was 680 cc 8/19/13 was 720 cc 8/20/13 was 680 cc 8/21/13 was 240 cc. During interview on 8/21/12, at 3:50 p.m., dietary director verified intake was provided by dietary for meals only and the other fluids given by nursing was to bed recorded by the nursing department. Document review of facility medication administration record dated 8/16/13-8/21/13, identified R57 required a 1.5 Liter total fluid restriction per day with the following instructions: 240 milliliters (ml) each meal, 240 between meals, (120-days, 120-afternoons, 60 cc night), and Nepro supplement 240 ml once a day. The medication administration record identified the following fluid intakes done by nursing: 8/16/13 was 360 cc combined with dietary gave a total of 840 cc this day 8/17/13 was 660 cc combined with dietary gave a total of 1380 cc this day 8/18/13 was 600 cc combined with dietary gave a total of 1280 cc this day 8/19/13 was 980 cc combined with dietary gave a total of 1700 cc this day which is 200 cc over allotted amount. 8/20/13 was 200 cc combined with dietary gave a total of 880 cc this day 8/21/13 was 840 cc combined with dietary gave a total of 1080 cc this day	F 327		

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F 327	Continued From page 20 However, it was learned that the total amount of fluids consumed each day from dietary and nursing did not include the water consumed in the room for the day. During interview on 8/22/13, at 1:00 p.m., director of nursing (DON) verified the lack of accurate monitoring of R57 ' s fluid consumption each day.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess, monitor, and review the use of antidepressants, antipsychotics, and hypnotics for 3 of 5 residents (R32, R15, and R26) reviewed for unnecessary medications. Findings include: R32 was on an antidepressant and hypnotic which were not assessed, reviewed, or monitored for effectiveness of continued use initially or ongoing. R32 was admitted on1/31/2011 and had diagnoses which included but not limited to: Heart failure, congestive heart failure, ischemic heart disease, polio, and hypertension. Physician orders dated 7/13 identified the resident on Trazodone HCL 50 mg as needed for insomnia and Melatonin 3 mg at bedtime as needed for insomnia. Physician review dated 7/15/2013 identified sleep disturbance and resident used Melatonin and Trazodone as needed. Medication sheets noted the following: for Trazodone as needed in 8/2013--none used; 7/13-none used; 6/13- used twice; 5/13-used 20 times; and 4/13-- resident took every night. For the use of Melatonin medication: 6/13 used more often than the Trazodone; 7/13 used almost every night; 8/13 used almost every night. On 8/22/2013 at 12:45 p.m., a licensed practical nurse (LPN)-B/care coordinator was interviewed regarding medication use. She indicated R32	F 329	F329: ZHS will ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. **R32** has ongoing daily monitoring of sleep habits to assess the effectiveness of the two prn medications for sleep. R32 has ongoing daily monitoring of specific target mood symptoms to assess the effectiveness of the antidepressant medication. An Analysis of sleep monitoring for R32 was completed and a Summary documented in a progress note on 9/20/13. An Analysis of mood monitoring for R32 was completed and a Summary documented in a progress note on 9/20/13. **R15** has ongoing monitoring of specific mood symptoms for the Antidepressant medication and ongoing monitoring of specific target behaviors for the Antipsychotic and Antianxiety medications in the medical record.	

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F 329	Continued From page 22 was using melatonin prn (as needed) instead of the Trazodone since it was started 5/22/2013. Started Trazodone initially on 3/26/2013 for sleep and had been on Ambien prior to that which was started on 3/12/2013. LPN-B verified an initial sleep assessment had not been completed prior to the initiation of hypnotic medications nor an ongoing assessment when the medications for sleep were changed. On 8/23/2013 at 9:00 a.m., the director of nursing (DON) and registered nurse (RN) consultant were interviewed regarding psychotropic medication reviews. Any resident started on anti-depressant or antipsychotic medication, the interdisciplinary team (IDT) identified the target behaviors at a meeting, visited with the medical doctor, checked check discharge summaries or history if the resident was in the hospital. The nurse aide ' s document episodes of no sleep per shift; anything specific or appropriate for the resident. The Minimum Data Set (MDS) nurse would develop the behavior data sheets that identify quantitative episodes. On the monitoring sheets staff chart by exception and then chart interventions. At the end of month, all information is taken to the IDT meetings and discussed. The discussion was supposed to be document but doesn't always get done but it should be written in the progress notes if the resident had medication changes, different interventions, etc. If the resident was stable and no change needed, then it wasn ' t documented. The insomnia monitoring was done over the 7 day assessment period. According to the DON, R32 was on Ambien for one day only. When questioned regarding a sleep assessment prior to initiation of the hypnotic medication, the DON indicated R32 had	F 329	F329 cont... An analysis and summary of the Mood and Target behavior monitoring data for R15 was documented on 9/2/13. The resident is on Hospice and received a Diagnosis of "Terminal agitation" **R26** had an analysis of Mood monitoring data with a Summary documented in the EMR on 9/2/13. Appropriate nursing staff that complete Mood and Behavior Assessments and document analysis of mood and behavior monitoring were re-educated on 9/20/13 regarding facility processes. Target mood or behavior symptoms will be identified for each psychotropic medication and will be monitored on a daily basis. These residents will be reviewed in IDT with discussions documented in a Progress note in the EMR. PRN Psychotropic medications will have non pharmacological interventions for the identified target behavior, to try before giving the medication. Each time there is a change in a psychotropic medication/dose, documentation shall be made in the EMR of the IDT discussion and decision, and monitoring will be initiated to assess the effectiveness of the change made. At least quarterly, and with a Sig Change in status, a Mood or Psychotropic Questionnaire assessment will be completed with an analysis and Summary documented in the EMR.	

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F 329	Continued From page 23 been on the Ambien medication for only one day. When asked about the other two hypnotics used for R32 the DON would not respond to the question. Evidence of assessment prior to initiation and ongoing use of hypnotic medications was requested at least twice and had not been provided. Also the continued use of hypnotics without a dose reduction was requested and again not provided. R32 was on an antidepressant medication (Celexa) without adequate monitoring and review. R32 had dose reductions in the antidepressant and review was not provided. Monitoring of the mood of R32 was collected but not for the months of 3/13, 4/13, 6/13, and 7/13. No summary or analysis of the data was provided to determine effectiveness of the antidepressant medications. Physician orders dated 7/13 identified R32 on Celexa (antidepressant medication) 10 mg daily. The facility provided monitoring of " negative statements " every day every shift. However, quantative data collection and analysis of the effectiveness of the antidepressant medication used was not provided even after having been requested at least twice from the DON. On 8/22/2013 at 2:15 p.m., the registered nurse (RN) consultant, and DON were requested to provide mood monitoring and medication review/analysis summary for effectiveness of the use of antidepressant medication or any other psychoactive medication use. The consultant indicated they do the mood review, which was data collection but staff did not summarize it. The	F 329	F329 cont... An audit of all residents on Psychotropic medications will be conducted by DON/designee to identify the necessary components are in place, by 9/30/13. Audit results will be brought to the QAPI committee for further review and any additional recommendations. Completion date: 9/30/13	9/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

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F 329	Continued From page 24 staff told her when there was no change they didn ' t do a summary. On 8/22/2013 at 2:45 p.m., the DON was interviewed. She verified no mood monitoring analysis was completed for R32. On 8/23/2013 at 9:00 a.m., the director of nursing (DON) and registered nurse (RN) consultant were interviewed regarding psychotropic medication reviews and mood monitoring. There was no written protocol or policy provided when requested. The RN consultant said that any resident started on an anti-depressant or antipsychotic medication, the interdisciplinary team (IDT) identified the target behaviors at a meeting. They visit with the MD. They check discharge summaries or history if the resident was in the hospital. The nurse aides document episodes per shift; anything appropriate for the resident. The MDS nurse would then do the behavior data sheets that identify quantative (terms of quantity) episodes. On the monitoring sheets staff chart by exception and chart interventions. At the end of month, all info is taken to the IDT meetings and discussed. The discussion was supposed to be documented but didn't always get in the progress notes if the resident had med changes, different interventions etc. If the resident was stable and no change, then it wasn ' t documented. Mood monitoring was done by nursing aides (NA). A more comprehensive assessment was done during that assessment period every quarter. The social service designee did the BIMS (cognition tool) and PHQ (patient health questionnaire) test and the RN ' s were to write a summary. As with the psychotropic reviews, the mood monitoring was discussed in IDT meetings	F 329		

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F 329	Continued From page 25 but didn't always get documented into IDT notes. Behavior, mood, psychiatric assessments would be done only on resident ' s with psychoactive and antipsychotic medications. R15 received antipsychotic, antianxiety and antidepressant medication however; R15 had a new order 7/1/13 for the use of the antipsychotic medication, which was a dose reduction. Monitoring of the mood of (tearfulness and anxiety) for R15 was collected and provided for 7/2013 but no documentation was provided for the months of 4/13, 5/13, 6/13, or 8/13. No summary or analysis of the data was provided to determine effectiveness of the antidepressant and antipsychotic medications. Also resident specific target behaviors including mood to monitor effectiveness of these three medications had not been completed. R15 was admitted on 4/13/2013 with diagnoses which included but not limited to: diabetes, congestive heart failure, depressive disorder, and heart disease. The resident was admitted to hospice services on 5/21/2013 for heart disease. Physician orders dated 7/1/13 identified R15 on Doxepin HCL 10 mg at bedtime for depression (4/18/2013), Paxil 10 mg daily for depression (4/18/2013), Ativan 0.5 mg daily on7/1/2013 and every 4 hours as needed (5/31/2013) for anxiety and restlessness and Haldol 2 mg every day (7/1/2013). On 8/22/2013 at 1:40 p.m., a licensed practical nurse (LPN)-B was interviewed regarding R15 ' s medications. She indicated a decrease in the Haldol had been attempted but failed. A more	F 329		

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F 329	Continued From page 26 recent attempt was done in 6/2013. The antidepressant Doxepin was reviewed and will slowly be reduced as of 8/21/2013 until discontinued. Behavior monitoring sheets dated 8/2013 revealed target behaviors as delusions/delirium, depressive statements/mood; increased anxiety/agitation, with no episodes; 7/2013-no episodes except 5 episodes for increased anxiety/agitation ; 6/2013-no episodes except noted several episodes of increased agitation/anxiety however there had been no specific symptoms identified as part of anxiety or agitation. Medication sheets were reviewed and the following was noted for the use of the as needed Ativan medication for the months of: 8/2013 had been used six times; 7/2013 had been used once; 6/2013 none documented used; 5/2013 had been used six times. The criteria used to give the Ativan medication was identified as anxiety/agitation. However, these were generalized terms that have a list of specific symptoms that each resident may exhibited one or more medical symptoms (What Are the Symptoms of an Anxiety Disorder? Symptoms vary depending on the type of anxiety disorder, but general symptoms include: · Feelings of panic, fear, and uneasiness · Uncontrollable, obsessive thoughts · Repeated thoughts or flashbacks of traumatic experiences · Nightmares · Ritualistic behaviors, such as repeated hand washing · Problems sleeping · Cold or sweaty hands and/or feet	F 329		

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F 329	Continued From page 27 · Shortness of breath · Palpitations · An inability to be still and calm · Dry mouth · Numbness or tingling in the hands or feet · Nausea · Muscle tension · Dizziness) to identify them as Anxiety or Agitation. The antidepressant medication and antipsychotic medication was given as ordered. On 8/22/2013 at 9:30 a.m., a licensed practical nurse (LPN)-A was interviewed regarding use of the as needed Ativan. LPN-A said the Ativan was given for anxiety related to shortness of breath and restlessness. The anxiety came from not being able to breathe. The documentation on the medication sheet only identified for anxiety/agitation. On 8/22/2013 at 2:15 p.m., the registered nurse (RN) consultant, and DON were requested to provide mood monitoring and medication review/analysis summary for effectiveness of the use of antidepressant medication and the antipsychotic medication use. The consultant indicated they do the mood review, which was data collection but staff did not summarize it. It was learned that a summary of the data collection was only done if there had been a change. On 8/22/2013 at 2:45 p.m., the DON was interviewed. She verified no mood monitoring summary had been completed for R15. A Behavior Assessment and Monitoring policy (undated) was provided by the facility. It read: Under Procedure: Monitoring: 1. If the resident is	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 28 being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function. A Behavior Assessment and Monitoring policy (undated) was provided by the facility. It noted the following: Under Procedure: Monitoring: 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual ' s behavior, mood, and function. R26 received Celexa, an antidepressant medication, without an analysis of the monitoring data to determine if the medication was effective. R26 was admitted 5/1/12, with diagnosis that included dementia without behaviors and depression. The facility identified R26 on the quarterly Minimum Data Set (MDS), as assessment dated 5/3/13, to have intact cognition, no behaviors, and received antidepressant medications. During observations on 8/19/13, at 6:12 p.m., 8/20/13, at 11:20 a.m., 8/21/13, at 11:00 a.m., and 8/22/13, at 7:15 a.m., R26 was observed to have no moods/behaviors exhibited. Document review of physician orders dated 7/1/13, revealed orders for Celexa 20 milligrams daily for depression. Document review of the facility April 2013 medication administration record revealed Celexa was decreased on 4/3/13, from 20 milligrams daily to 10 milligrams daily, and on 4/27/13,	F 329		

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F 329	Continued From page 29 Celexa was increased to 20 milligrams. Document review of the facility medication administration record dated 6/1/13-6/30/13, 7/1/13-7/31/13, and 8/1/13-8/22/13, revealed R26 received Celexa 20 milligrams daily as ordered. R26 ' s care plan dated 4/1/13; directed staff R26 had behavior and anxiety, with health complaints and attention seeking behaviors. The care plan directed to provide re-orientation, 1:1 time with resident, re-direct, and monitor mood every shift. Document review of monthly mood/behavior monitoring for Celexa, revealed the following: 7/1-31/13 revealed target attention seeking behaviors one time with intervention of 1:1 successful; continual health complaints one time with intervention of 1:1 successful. 8/1-22/13 revealed target of attention seeking behaviors and continual health complaints and none had occurred. Document review of the facility behavior data sheet read: June 2013-attention seeking behavior-none; health complaints-three times, interventions included medication successful two times, reassurance successful three times; warm/cold pack successful three times; confusion-14 times; anxiety nine times, and tearfulness four times. July 2013-attention seeking behavior-one time, intervention 1:1 successful; health complaints 1 time, intervention 1:1 successful; confusion 21 times, anxiety nine times, and tearfulness one time. Document review of the facility mood review	F 329		

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F 329	Continued From page 30 dated 1/29/13, 5/2/13, and 8/1/13, identified minimal depression and lacked analysis of mood monitoring data. During interview on 8/21/13, at 3:15 p.m., director of nursing stated she was responsible to conduct mood/behavior analysis/summary. During interview on 8/22/13, at 2:15 .pm., director of nursing stated she did not conduct analysis of mood monitoring because there was no change in status. During interview on 8/22/13, at 2:45 p.m., director of nursing verified the lack of mood monitoring analysis for R26. Document review of facility policy Behavior Assessment and Monitoring with no date, read: Monitoring- " 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function."	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		

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F 353	Continued From page 31 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interviews, record review and complaint review, the facility failed to ensure care and services were provided to prevent decline in ROM for one of one resident (R1) reviewed for nursing rehabilitative services. In addition the facility failed to reduce the potential for falls and falls with injury for sixteen of sixteen residents (R49, R26, R6, R51, R16, R34, R25, R39, R22, R15, R27, R45, R23, R54, R37 and R29). This had the potential to affect all resident in the facility. Findings include: Insufficient staffing was identified by residents, family and staff during stage one of the survey. In addition a complaint had been received by the state agency that staffing was not adequate in the facility on 7/10/13, 4 nursing assistants (NA) were scheduled for the day shift however, two NAs were sent home, one at 12:30 p.m. and one at 1:30 p.m., the facility had a census of 34 at this time which left 2 NAs to provide cares and services for the 34 residents for the shift. During the day shift there were concerns with seven residents who had bowel incontinence due to prolonged time to wait for staff to assist them with	F 353	F353: ZHS will ensure nursing care and services will be provided to all residents in accordance with resident care plans. Refer to F318 for interventions for ROM and F323 for interventions Falls. To ensure adequate staffing at ZHS, pool staffing agencies are been utilized on a temporary basis thru 10/31/13 until all new staff have been adequately trained and hired. A Job Fair was held at ZHS on 9/10/13. 8 job offers were extended to RNs, LPNs, and NARs. 5 offers have been accepted as of this writing. Staff retention committee has been formed of non- manager staff representation from each department at ZHS and the HR director and the administrator. This committee will meet on a monthly basis. Results of committee concerns and ideas will be discussed at QAPI meetings. Front line floor staff are being involved in decision making process of how staff is recognized, and are able to give valuable feedback to the training process of new employees, day to day work environment and how these processes affect resident care. Staffing schedules will be reviewed on a daily basis by Administrative staff. Hours will not be flexed down when census is 34 or above, or when acuity of residents is high despite lower census.	

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F 353	Continued From page 32 toileting. Insufficient staffing did trigger for stage II investigation. On 8/20/13, at 11:33 a.m. during a stage one interview, a family member (F)-A stated he is here to help mother eat all three meals and commented that facility is " shorthanded and needed more help. " R1 stated she did not receive range of motion (ROM) exercises every day as ordered because the facility did not have enough help. See F318: Based on observation, interview and record review the facility failed to provide consistent nursing rehabilitative services for 1 of 1 resident (R1) who had an order for daily range of motion of extremities. The nursing rehabilitative nurse was pulled from performing rehabilitative services to assist with resident cares and the facility had decreased nursing assistant staffing due to a decrease in resident census and this negatively impacted R1 from receiving rehabilitative services as ordered by the physician. See F323: Based on observation, interview and documentation, the facility failed to provide care an services sufficiently to reduce and prevent falls for residents with frequent falls for 3 of 16 residents (R49, R26, and R6) who had frequent falls and some falls were related to staff response and supervision. R51 was admitted to the facility on 6/10/2013, the admission data base did not include diagnoses. The MDS dated 6/20/13, had a BIMS score of 9 indicating moderate cognitive impairment. R51 required extensive assistance of one staff with bed mobility, transfers, and locomotion on and off the unit, dressing, toilet use, and personal hygiene, limited assistance of one for ambulation	F 353	Results of resident satisfaction surveys will be reviewed by facility staff and follow up made on all concerns. Results of resident satisfaction surveys will be brought to the QAPI committee for review and further recommendations. Completion date: 9/30/13	9/30/13

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F 353	Continued From page 33 on and off the unit, and supervision for eating. The care plan dated 8/23/13 indicated R51 ambulated with a walker and assist of one staff. Had behavioral signs and symptoms of depression and needed his call light answered immediately for reassurance and needed a consistent environment. R51 had moderate cognitive impairment, required directions one at a time, allow time to respond to questions, for decision making, and keep the call light within reach. R51 received restorative nursing for transferring safely with assist of one staff, dressing, and supervision with eating to prevent aspiration. R51 was a fall risk, had a floor matt and was to have the call light within reach. R51 had a history of difficulty sleeping and staff was directed to promote environment conducive to sleep, minimize interruptions and disruptions during sleep, avoid loud noises and speaking outside of resident room, and allow the resident choice of when to get up or when to sleep. Bilateral macular degeneration was identified; R51 used a magnifying glass for reading and required a consistent environment. On 7/5/13, at midnight R51 was found on the floor at the side of his bed, stated he was getting up to the bathroom and slid to the floor, and still felt week from the flu, gripper socks in place; the immediate intervention was hourly safety checks. The Incident Report identified self-transfer as the cause of the fall. The root-cause analysis (RCA) was resident status related to recent gastro-intestinal bleeding; The Incident Report Quick Review form dated 7/5/13, had RCA progress notes that indicated R51 had a history of poor insight into abilities. The facility census sheet was not provided. On 7/5/13, at 7:30 a.m. R51 was found on the floor by maintenance and R51 stated, "slipped out of bed" R51 later	F 353		

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F 353	Continued From page 34 stated, "I did try to stand up by myself; I just forgot that I can not do it" gripper socks were in place. The immediate intervention was monitoring, monitoring vital signs and safety checks. The RCA identified a cause was the amount of assistance in effect and the intervention to prevent future falls was to put an anti-skid mat on the floor by the residents bed. The Incident Report Quick Review form dated 7/5/13, at 7:30 a.m. had RCA progress notes that indicated " poor insight and forgetfulness into ability." The facility census sheet was not provided. On 7/20/13, at 1:20 p.m. staff responded to pendant call light and found R51 lying on the floor next to his bed. R51 stated he fell out of bed, because he was going to the bathroom. The safety interventions already in place were the call light within reach and the bed was in low position. The immediate intervention was to put a tab alarm (a magnet attached to the patient clothing that when separated from the alarm device, caused the alarm to sound) to alert staff to unsafe self-transfer attempts. The immediate interventions were monitoring, monitoring vital signs, the tab alarm and a request for a bed alarm when available. The RCA identified the resident declined the use of the urinal during routine rounds (un-timed) and identified footwear as a contributing factor. The initial interventions were gripper socks, the tab alarm placed, since a bed alarm could not be located. The RCA progress note indicated a history of self-transfer, need reminders to use the call bell, and was on an air pressure mattress related to a history of open area on the coccyx. The interventions identified by the DON were a " Call Don't Fall " sign (even though the resident required a	F 353		

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F 353	Continued From page 35 magnifying glass for reading) and tab alarm to be replaced with bed alarm. The facility census was 35 at this time. R16 was admitted 10/15/2007, with admission data base diagnoses of cancer of the rectosigmoid junction (intestines), dementia, senile dementia, and cerebral ischemia. The quarterly MDS 5/30/13, had a BIMS of 8, indicating a moderate cognitive impairment. R16 required extensive assistance of two staff for bed mobility, and extensive assistance of one staff for transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene; supervision cueing and oversight for eating. The care plan dated 3/26/13, indicated R16 ambulated 50 feet twice a day with a walker, assist of one staff and a gait belt, followed by a wheelchair. The behavioral care plan was updated to indicate R16 was no longer able to use the call light, needed decreased stimulus in the environment and a consistent environment and routine. The cognitive impairment care plan indicated R16 was forgetful, and to place the call light within reach. The safety care plan indicated a bathroom door motion sensor alarm had been in place and was removed on 3/25/13. On 8/5/13, at 6:35 p.m. a nurse heard R16 yelling for help, R16 was found on the floor of the bathroom lying on his right side, holding himself up. R16 stated he was self-transferring from the wheelchair to the toilet and landed on his buttocks. R16 was noted to have light reddened areas on his left upper arm, extending upward to the shoulder, a reddened quarter size area on the mid-back, and petechiae (A petechia ; plural petechiae is a small (1-2 mm) red or purple spot on the body, caused by a minor hemorrhage (broken capillary vessel) on the left side. The call light was within reach and the wheelchair brake	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 36 was on. Immediate intervention was monitoring of vital signs. The RCA progress note indicated a motion sensor alarm would be attached to the bathroom door. On 8/5/13, the census was 34 and staffing had been flexed down. R34 was admitted 6/5/13, the admission data base did not include diagnoses. The discharge MDS dated 7/22/13 indicated intact cognitive functioning, R34 required extensive assistance with weight bearing support for dressing and personal hygiene, limited assistance with limb guidance and non-weight bearing support for transfers and toilet use. The care plan dated 8/23/13 indicated R34 ambulated with a walker, and did not have behavioral issues. On 6/20/13, R34 self-reported a fall at 04:45 a.m. R34 had self-toileted and stated she had been up to the bathroom 4 times during the night and felt dizzy while exiting the bathroom with the walker. R34 returned to bed and then used the call light to notify staff of the fall. R34 sustained two skin tears to the right elbow and one skin tear to the right wrist. The skin tears were cleansed and dressed. The immediate intervention was to encourage the resident to use her call light for assistance during the time being, R34 was able to demonstrate call light use. The facility census was 37 at this time. R25 was admitted on 11/5/2009, with admission data base diagnoses of prostate cancer, bladder cancer, anxiety, insomnia, depression and difficulty walking. The quarterly MDS dated 5/15/13, indicated R25 was cognitively intact. Required limited assistance and guided limb maneuvering for personal hygiene, and was otherwise independent. The care plan was requested but not provided.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 37 On 6/23/13, at 02:13 a.m. R25 was calling out for help and was found on the bathroom floor and did not have the walker. R25 stated he had used the toilet. R25 sustained 3 scratches to the back of the right arm and shoulder. The immediate intervention was hourly checks and a reminder to use the walker during ambulation. The RCA indicated contributing factors were lack of walker, medical status, and toileting status. The RCA progress note indicated resident had a history of manually removing stool, the fall was determined an isolated incident. The facility census was 34 and staff had been flexed down. On 8/10/13, the Incident Report indicated at 10:00 a.m. R25 was found lying on his back in the doorway of the room. R25 was wearing shoes; the wheelchair and walker were not near the recliner as per the care plan. The fall scene investigation indicated a wet floor. R25 had been cauterized for 600 milliliters output and then placed in the recliner chair; the call light was within reach. The RCA progress note lacked documentation. The facility census was 37 at this time. R39 was admitted 5/2/2012, with admission data base diagnoses of dementia, recurrent depression with mild psychosis, anxiety, Parkinson's disease, The quarterly MDS dated 5/17/13, had a BIMS of 13 which indicated R39 was cognitively intact and required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use. Limited assistance of one, non-weight bearing support with personal hygiene and ambulation in the room and in the corridor. . Limited assistance of one with weight bearing support locomotion on and off the unit. The care plan dated 5/31/13, indicated R39 ambulated with a walker, had visual	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 38 hallucinations, and some confusion to place, made negative statements, had agitation and restlessness. R39 responded to simple directions, one at a time; was independent with transfers and should have the call light within reach. On 7/17/13, the Incident Report indicated R39 was found sitting on the floor in her room, the walker was standing upright and backwards in the bathroom; R39 stated she was headed into the bathroom when she lost her balance. R39 stated she say stool all over the floor, but staff noted the floor was clean. The immediate intervention was hourly safety checks and to re-educate on how to use the walker properly, encouraged to use the call light to ring for assistance with transfers/ambulation. The RCA progress note indicated a history of confusion, hallucinations and delusions at times that affect ability to perform transfers. The facility census was 34 and the staffing had been flexed down. On 8/16/13, at 08:45, R39 was found on the floor, stated she had been bending over to pick up dropped candy and fell out of the wheelchair, which was unlocked. The Incident Report indicated the call light was within reach and her shoes were on. The immediate interventions were monitoring, monitoring with vital signs, neurological checks and to put the call light within reach, the candy was moved to a bowel on the night stand. The RCA progress note intervention stated R39 needed reminders to call for assist; the candy was put in a bowel on the night stand. The facility census was 36 at this time. R22 was admitted on 12/18/2008, with admission data base diagnoses of depression, enlarged prostate, asthma, and lung disease. The quarterly MDS dated 7/30/13 had a BIMS of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 39 12 which indicated moderate cognitive impairment. R22 required extensive assistance and weight bearing support with personal hygiene, supervision and cueing for bed mobility, walking in room, dressing and toilet use but was independent with transfers, walking in the corridor, locomotion on and off the unit and eating. The care plan indicated R22 ambulated with a wheeled walker, had seasonal depression, R22 required time for decision making, used Meclizine as needed (anti-vert, a medication that prevented dizziness), and was independent with transfers. On 7/19/2013, at 07:00 a.m. the resident was found yelling in his room with the door closed. R22 was found sitting on the floor with his back against the bathroom wall, with his walker within reach. R22 stated he had a dizzy spell. The immediate intervention was to give the Meclizine medication, monitoring, monitoring vital signs, and a stand by assist with ambulation for the remainder of the shift and as needed. The facility census was 35 at this time. R15 was admitted on 4/10/2013, with admission data base diagnosis of subacute delirium. The significant change MDS dated 6/10/13 indicated a moderate cognitive impairment. R15 required extensive assistance of one staff with weight bearing support for bed mobility, transferring, dressing, toilet use, personal hygiene, ambulation in room and in corridor, locomotion on and off the unit; and supervision with cueing for eating. The care plan dated 8/23/13 indicated R15 ambulated with a walker and assist of one staff, had a varying need for assist with transfers; had a history of delirium and depression, was on continuous oxygen during the day; was at risk of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 40 falls, had a bedside floor matt, and needed the call light within reach. On 7/27/13, at 4:15 a.m. The Incident Report indicated R15 was found next to the bed on her knees, laughing and stated she had rolled out of bed. The immediate intervention was safety checks, monitoring, monitoring vital signs, and the blood sugar was checked. The RCA progress note indicated R15 was independent with bed mobility, needed cues with positioning and to use the grab bar. Determined to be an isolated incident. The intervention was to encourage R15 to use the call bell and to alert staff to assist with positioning when restless. The facility census was 37 at this time. R27 was admitted on 10/15/2011, with admission diagnoses of depression, brain injury, seizures, and stroke The significant change MDS dated 5/28/13, indicated a severe cognitive impairment, R27 required extensive assistance of one staff with weight bearing support for bed mobility, transferring, dressing, toilet use, personal hygiene, ambulation in room and in corridor, locomotion on and off the unit; and supervision with cueing for eating. The care plan dated 7/16/13, indicated R27 ambulated with a wheeled walker, did resist cares and was confused every shift, had a severe cognitive impairment; had a history of falls and seizures, the wheelchair had anti-rollback brakes, had bed and chair alarms. On 6/2/13 at 1:45 p.m. the Incident Report indicated R27 was found sitting on the floor and trying to get back up. R27 stated he was trying to dump the coffee cup into the bathroom sink. R27 sustained a skin tear on the right knuckle, the skin tear was cleansed and closed with	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 41 steri-strips; the wheelchair alarm was not turned on. The immediate interventions were the skin tear was dressed, monitored vital signs, and a "call don't fall" sign was placed near the bathroom door. The RCA progress note indicated intermittent confusion and impulsive actions. The fall was reported to the SA because the care plan was not followed. The facility census for 6/2/13 was requested but not provided, the staffing was flexed down. On 6/15/13, at 8:00 p.m. the Incident Report indicated the NA heard a boom and noted R27 on the floor two feet from the bed with the bed alarm going off. R27 was trying to reach something in the wheelchair, did complain of some lower back pain. R27 was placed back into bed; the call light was placed within reach. R27 sustained scratches on his mid and lower back. Attempted to self-transfer two additional times on the shift. The initial intervention was to re-orient to the call light and discuss the need to call for assistance when needing help. The RCA progress note indicated history of self-transfers, place belongings within reach, and prevent un-necessary reaching, self-transfers. The facility census for 6/15/13 was requested but not provided, the staffing was flexed down. On 7/23/13, at 8:30 p.m. the Incident Report indicated R27 was found sitting on the floor in the bathroom and stated he had tried to grab the bar on the right side of the toilet and tipped backwards. The walker was outside of the bathroom. The immediate intervention was safety checks, monitoring, and monitoring vital signs. The root cause was determined to be abnormal vital signs and medical status. The vital signs were not documented in the Incident Report. The RCA progress note indicated a history of self-transfer, impulsiveness; R27 had been	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 42 working with therapy to increase strength with gait and transfers. The intervention was hourly safety checks. The facility census was 37 and the staffing was flexed down. On 7/25/13 at 8:30 p.m. R27 was found lying on his right side and stated he was returning from the bathroom, lost his balance and bumped his head. Water droplets were around R27 and an uncovered water glass was noted in the walker. The immediate intervention was to monitor vital signs, and neurological checks, R27 was reminded not to transport uncovered glasses of water in his walker. The incontinent product had been changed at 7:00 p.m. The RCA progress note indicated R27 self-transfers and had end of day weakness. Reminded not to transport uncovered liquids. The facility census was 37 and the staffing was flexed down. On 8/8/13, at 8:10 p.m. Resident had been self-transferring, was found when the bed alarm went off, was being assisted by one NA and a gait belt, but started to lean to the right and fall and was noted to lightly bump his head on the bedside table. Immediate intervention was to place a "call don't fall" sign near the resident ' s room. The RCA progress note indicated a history of poor balance, and a "call don't fall" sign was placed near the resident. The NA was re-educated on transfers. The facility census was 37 at this time. R45 was admitted on 12/6/12 with admission data base diagnoses of brain cancer, convulsions, memory loss, and altered mental status. A quarterly MDS dated 6/26/13, indicated intact cognitive functioning, R45 required supervision for dressing and personal hygiene and was independent in all other tasks. The care plan dated 8/23/13, indicated R45	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 43 ambulated independently, had anxiety, pacing, rummaging and wandering, needed directions one at a time. On 8/15/13, at 10:05 p.m. R45 was found lying on the floor with her blankets and stated she had attempted to find the basin as she needed to vomit. R45 had not felt well and had taken in no solid food only sips of water. R45 sustained a 1 centimeter (cm) laceration to the middle of the forehead, swelling and bruising was noted on the forehead, along the bridge of the nose and the inner left eye. A small skin tear 1.5 cm to the right elbow. Immediate intervention was to place R45 on 15 minute safety checks, and the call light was placed on her chest. The RCA progress note indicated R45 independent in her room, 15 minute checks. The facility census was 36 at this time. R23 was admitted on 3/23/2009 with admission data base diagnoses of degenerative basal ganglia (brain disease), and adult failure to thrive. A quarterly MDS review dated 6/11/13, indicated a cognitive assessment was not able to be completed, R23 required extensive assistance with weight bearing support for bed mobility, transfers, dressing, personal hygiene, ambulation, locomotion, and eating. The care plan dated 4/2/13, indicated R23 ambulated with four wheeled walker, assist of one with gait belt to all destinations due to balance problems when walking, a bathroom door alarm was in place; no cognitive deficits, and to place the call light within reach. On 7/4/13 at 12:50 p.m. the Incident Report indicated R23 was found on the bathroom floor yelling for help after self-transferring. The immediate intervention was safety checks, monitoring, and monitoring vital signs. The RCA	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 44 progress note indicated history of self-transfer and impulsive transfer, the intervention was care guide pocket audit and staff education, the fall was reported to the SA as the interdisciplinary team identified the care plan was not followed. The facility census was requested but not provided. R54 was admitted on 3/29/13 with admission data base diagnoses of encephalopathy. A quarterly MDS review dated 7/10/13 indicated a moderate cognitive impairment. R54 required extensive assistance from two persons for bed mobility, transfers, ambulation, locomotion, toilet use and dressing; extensive assistance of one person for personal hygiene and eating. The care plan dated 5/7/13, indicated R54 was not ambulatory and was transferred into the chair with assist of two staff at least one time a day, needed her call light answered immediately for re-assurance. R54 had moderate cognitive impairment and needed to be oriented to place and have the call light within reach. Was at risk of falls and had a perimeter mattress and bedside floor matt. On 6/3/13, at 7:10 p.m. the Incident Report indicated R54 was found sitting on the floor next to the bed, holding on to the bed grab bar with her right hand, gripper socks were on and the call light was lying on the bed within reach. R54 was attempting to climb into bed. The immediate intervention was hourly checks. The root cause analysis indicated the amount of assistance in effect contributed to the fall, and noted the family declines an alarm at this time. The census sheet was requested but not provided. R37 was admitted on 7/8/13, the admission data base did not indicate a diagnosis.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 45 The admission MDS dated 7/19/13, indicated moderate cognitive impairment, R37 required extensive two person assistance for bed mobility, transfers, and toilet use; extensive assistance of one person for locomotion, ambulation, dressing, and personal hygiene; R37 was independent with eating. The care plan dated 8/23/13 indicated R37 ambulated with a wheeled walker, and needed assist of one with transferring. On 7/25/13 at 1:25 a.m. the Incident Report indicated a loud noise was heard along with a cup falling and R37 was found on the floor in front of his bed, R37 stated he had been standing and reaching for his urinal, knocked over his water glass and slipped and fell to the floor. The immediate intervention was to put gripper socks on the resident and add it to the care plan to place them on every night at bedtime. The root cause analysis indicated the amount of assistance needed and footwear was lacking. The RCA progress note indicated poor judgment with ambulation ability, the intervention was gripper socks. The facility census was 37 and staffing was flexed down. On 7/25/13 at 5:20 a.m. the Incident Report indicated a loud crash was heard and R37 was found sitting on the floor in his room, the resident stated "he was looking for something" the bedside tray was noted to be near the resident across the room. R37 sustained a large bruise on the left elbow with four small skin tears within the bruised area. Dressed with non-stick telfa and wrapped with kerlix. Immediate intervention, tab alarm was placed on the patient and bedside tray was removed from the room. The root cause analysis indicated the amount of assistance needed and environmental factors. The RCA progress note indicated "multiple reminders to	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 46 use the call light and resident does not use the call light but self-transfers." The intervention was to remove the wheeled bedside table from room, and tab alarm placed. The facility census was 37 at this time. R29 was admitted 2/15/13, with admission data base diagnoses of alcohol abuse, cirrhosis of the liver. The significant change MDS dated 6/25/13 indicated R29 was unable to complete a BIMS, required extensive assistance of two persons for bed mobility, transfers, ambulation, locomotion, dressing, toilet use, personal hygiene and extensive assistance of one for eating. The care plan dated 8/23/13, indicated R29 ambulated independently with a walker and independent with transferring, resisted cares, experienced confusion every shift, had a moderate cognitive impairment and needed to be re-oriented to place and time, and have the call light within reach. Was at risk of falls, had a bed sensor and wandering alarm in use. On 6/15/13, at 8:15 a.m. the Incident Report indicated R29 was reaching for his blanket and slipped out of his recliner, was caught and lowered to the ground by a staff member. The immediate intervention was safety checks, monitoring and monitoring vital signs. The root cause was medications and medical status (receiving pain medication and anti-anxiety for pain related to hospice care). The RCA progress note indicated keep personal belonging within reach and provide calming environment. The facility census was requested but not provided, the staffing was flexed down. On 6/16/13, at 10:22 p.m. the Incident Report indicated R29 was attempting to self-transfer from the recliner and fell to the floor. Resident	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 353	Continued From page 47 stated he was trying to go swimming. Immediate interventions were to use a one to one related to increased anxiety and restlessness for the remainder of the shift. The RCA progress note indicated delusions from medications for comfort and agitation. The intervention was one to one as needed and calls Hospice to request a new chair. The facility census was 34 and staffing was flexed down. On 6/22/14, at 8:40 a.m. the Incident Report indicated R29 was found in his room calling on the floor on his hands and knees; R29 had been toileted and laid down 10 minutes before the fall. Immediate interventions were monitoring vital signs and a fall matt was placed. The facility census was 34 and staffing was flexed down. On 6/23/13, at 4:31 p.m. the Incident Report indicated R29 was watching a movie, R29 called out and the tab alarm sounded R29 was found on the floor in front of the Broda chair. R29 had a bump on the right forehead and moderate bleeding from the right eyebrow from a 0.5 cm laceration and re-opened skin tears to the right arm. Immediate interventions were ice pack to forehead, lacerations and skin tears were cleansed and steri-stripped. Geri sleeves were applied bilaterally. Pressure alarms were added to the wheelchair. The RCA progress note indicated increased delirium and the intervention of pressure alarm added to the wheelchair. The facility census was 34 and staffing was flexed down. On 6/26/13, at 9:00 a.m. the Incident Report indicated the pressure alarm sounded and R29 was found on the floor kneeling next to the bed. The root cause was noted to be mood or mental status. The initial intervention was gripper socks placed on R29. The RCA progress note indicated increased delirium, encourage gripper socks, and	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 48 a lip mattress was provided by hospice. The facility census was 34 and staffing was flexed down. On 7/3/13, at 7:00 a.m. the Incident Report indicated R29 was found on the floor in his room. The root cause was determined to be mood or mental status, the initial interventions stated bed changed to lipped mattress from hospice (although this was completed on 6/26/13). The immediate intervention was safety checks and monitoring vital signs. The RCA progress note indicated the intervention was a body pillow. The facility census was 33 and staffing was flexed down. On 7/8/13, a progress note indicated increased falls over the last three weeks due to increased delirium from end of life liver disease, hospice resident on morphine for comfort and Ativan for agitation and restlessness. A Broda chair (a padded reclining wheelchair) and lipped mattress. R29 was on 15 minute checks with one to one intervention as needed. A low bed with a fall matt was in place. Gripper socks are encouraged and R29 was offered food and fluids with cares, staff remove pedals from Broda chair so he cannot stand on them. A body pillow had been added as a fall intervention while the resident is in bed. The facility census was 32 and staffing was flexed down. On 7/10/13 at 8:05 p.m. the Incident Report indicated staff responded to bed alarm and found resident on the floor next to the bed. Immediate interventions were monitoring vital signs and started a movie. The RCA progress note indicated motion sensor alarm ordered. The facility census was 34 and staffing was flexed down. On 7/18/13, at 5:28 a.m. the Incident Report indicated the alarm was sounding and the	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 49 resident was found on the floor next to the bed, speech was garbled due to declining status on Hospice. A small laceration above the left eyebrow area, pressure was applied until bleeding stopped; the laceration was cleansed and dressed. The immediate intervention noted was 15 minute checks were in place, a bed alarm was in place with fall matt and low bed, the call light was within reach. The RCA progress note indicated a larger and thicker fall matt was placed. The facility census was 35 at this time. A review of the staffing sheets for June, July, and August 2013 revealed changes made with white out on 81 out of 81 days reviewed. The staffing sheets also indicated that staffs were either sent home (flexed down) after a partial shift, or call-ins were not replaced. A review of the staff posting sheets which contained the census information for the facility indicated the facility had between 34-37 residents. The resident satisfaction forms for June and July 2013 provided by the facility identified not enough staff after dinner meal, extended call light times, staff was unable to spend enough time with a resident and call lights take a long time to respond too. The call light logs were requested from the Arial call light system and the facility stated that they destroy the logs after they are reviewed so none were provided. A summary of the June 2013 call light audits provided by the facility indicated in June 2013 a random sample of 424 the average time (the call light was on) was 4.87 minutes. A summary of July 2013 indicated a sample of 134, the average time the call light was on was 5.32 minutes. A comparison of fall rates for 1000 resident days was requested for June and July 2012 vs. 2013	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 50 and indicated a fall increase from 5.96% to 11.7% in June 2013, and from a 2.8% to 21.8% in July 2013 despite higher staffing levels in 2013. The facility stated they had identified staffing interventions and provided a plan. The facility identified an employee referral program was in place; extra pick up pay implemented when necessary; increased pay rate for on call employees to get more hired on; nursing assistant class help on site Sept/Oct 2012; Switched licensed staff to 12 hour shifts and work every 3rd weekend, as a more appealing option. In the last month: a sign on bonus for licensed staff; looking into two funded programs offering employment opportunities for elderly and/or disabled people to do work in the facility. Increased advertising, staff retention committee formed, first meeting scheduled 8/29/13, and mentor program for nursing department in its final planning stages. Hired five full time NAs with incentive of a sign on bonus and job fair planned for September 2013. On 8/22/13 at 8:00 a.m. Licensed practice nurse (LPN)-A stated she worked on all three shifts, that she was asked to come in early, stay late and work overtime frequently, in addition LPN-A stated that about 50% of the time they have the staff to complete the work required by the residents. On 8/22/13 at 9:30 a.m. nursing assistant (NA)-C stated that she works days and nights, comes in early, stays late and works overtime. NA-C further stated that they do not have enough help and they may be short on any shift, when people are sent home because of low census you may not be able to respond when you hear a chair/bed alarm sound, because you can't leave the person you are working with at the time. NA-C verified	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 51	F 353		

that residents have fallen when the staffing was short because everyone was tied up with another resident.
On 8/22/13 at 9:40 NA-A stated that aides have been sent home early because of a census decline, and that when that happens, you can't get everything done.
On 8/22/13, at 10:04 a.m. the director of nursing (DON), staffer, and consultant nurse (CN) were interviewed regarding staffing. The staffing pattern is determined by census and acuity in the building, the usual staffing patters for the day is 1 nurse and 1 trained medication aide (TMA) for 4 hours in the morning and four nursing assistants for assignments on the floor, depending on acuity and census fill all 4 of the NA assignments for the full 8 hours. They have started a 12 hour shift from 10:00 a.m. to 10:00 p.m. usually the nurses work 8 hour shifts. They used to sometimes have a short NA shift from 2:00 p.m. to 6:00 p.m. when the census was above 42, but the census is now capped at 42 so do not utilize that shift anymore, unless very high acuity in the building. Night staffing level is a nurse and two nursing assistants. When the staffer is not available the DON or director of human resources (HR) does the staffing. When sick calls can't be replaced they mandate from the previous shift to stay and keep a list of who was mandated last, this was utilized the past weekend. The decision to flex down was an administrative directive when the census declined to 32, today's census was 35. Staffing is tracked and trended with incidents (falls, etc.) and patterns were discussed in quality improvement meeting. The facility had been addressing shortages by using the restorative aide weekdays, and sometimes in the morning to help with early risers. Staffing can be flexed for staff ' s daycare issues, with staff, or census.

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 52 Staff on orientation was not counted in the facility staffing for that day. A review of the fall with head laceration on 7/3/13 and the staffing sheets for that day revealed R49 fell on a day that staffing was flexed due to low census; this was verified by the DON. Additional falls were reviewed on days that staffing was flexed down due to low census. A review of the fall 7/23/13 at 2:45 p.m. revealed R6 was found on floor next to bed, he was pushing recliner remote attempting to get chair to recline backward more, but went in the wrong direction, therefore raised chair, res slide out. A skin tear injury required steri-strips to repair and was covered with kerlix. The DON verified the NA's were short one on days and one on evenings, and stated she would need to check to see if the census was down that day. The DON stated, "those are the days that we do not do paperwork and we are out there answering call bells, helping in the dining room, toileting, bringing people back and forth from meals, so the NA's can concentrate on repositioning and those kinds of things. " The consultant RN asked if the DON had related any falls to short staffing, since she had investigated them and the DON did not answer the question. The DON stated she had worked seven of the last eight weekends because of short staffing and had put in one 12 hour NA shift and was then unable to move from the couch. On 8/22/13 at 2:20 p.m. the administrator stated staff occasionally, bring different ideas to her and the facility try to incorporate ideas into rearranging schedules and times. The administrator further stated the facility does conduct exit interviews and she would need to double check forms to see if short staff was	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 53 mentioned. The administrator stated they had zero major injury in June and July 2013 from falls. The staff turnover rates for June 2013 were for RN at 3%, LPN at 11.1% and NA at 11.8%. On 8/22/13 at 2:25 p.m. registered nurse (RN)-A verified that ROM was being done for R1 on average five out of seven days a week, and the other days they were too short to do ROM. On 8/22/13 at 3:00 p.m. NA-B stated the staffing is sufficient only when the restorative aide is pulled into the floor staff, but then other important things don't get done. On 8/22/13 at 2:40 p.m. the human resource person (HR) was interviewed and stated generally try to run orientation once per week. Last Wednesday group of five NAs went through, next Wednesday 8/28/13; there will be one dietary aide and one full tine NA. The facility had 89 total employees, of those 24 full time equivalents (FTE) are NA, two TMA's are not counted in that FTE. There were seven LPN's and five RN's counted in direct resident care. The HR verified there had been a staff injury in the past two months, which involved a lifting task, but the employee is now back to work without restrictions. Two LPN's quit without notice, one was going back to school and declined an offer to reduce FTE and work with the schedule citing a personal issue. The other declined the exit interview, had called in at 11:00 p.m. on 7/10/13 for a morning shift on 7/11/13, the unemployment hearing was decided for the facilities favor. The HR stated the July 2013 NA turnover rate was 5.6%, LPN was 0%, and RN was 0%. The turnover rate was calculated by the HR director on the spot and HR director stated the rate was calculated taking into account the number of hires as well as number of resignations or terms and	F 353		

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 353	Continued From page 54 that was why the LPN was 0%. On 8/23/13, at 7:45 a.m. The administrator and DON provided the falls rates for June and July 2012 and June and July 2013 for 1000 patient days The call light summary requested 8/22/13, during the interview with the DON, HUC/staffer, and consultant nurse. The DON provided (in the presence of the administrator provided the redacted quality assurance quality improvement (QAQI) minutes with the requested call light log/audit summary and in addition a staffing analysis and a resident fall summary that was provided to the QA committee (the QAQI minutes had not been requested, but were delivered by the facility). The Mandatory Overtime policy dated 5/13/10, read "mandatory overtime is defined as any employee required to work hours exceeding the length of a normal shift. Mandatory overtime will be utilized to ensure appropriate staffing to meet resident needs and state guidelines for staffing. The authority to initiate mandatory overtime shall be vested with the DON or administrator." "Mandatory overtime may be invoked on any employee to ensure proper resident care due to emergency staffing situations. " "Emergency staffing situations are defined as a period when replacement staff are not able to report for duty for the next shift or increased patient need, because of call ins, unusual, unpredictable, or unforeseen circumstances such as, but not limited to, a disease outbreak, adverse whether[sic] conditions, or natural disasters which impact continuity of patient care." Any additional staffing policies were requested but not provided by the facility.	F 353		

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly handle, store and process residents personal laundry to minimize cross contamination; failed to provide personal protective equipment for staff use to protect their body and/or clothing from potential illnesses and hazards that could cause injury and failed to store reusable equipment in a sanitary manner. This had the potential to affect 34 of 34 residents who resided in the facility. Findings include: FACILITY FAILED TO MAINTAIN THE DESIGNATED LAUNDRY AREAS, EQUIPMENT AND PRACTICES IN A SANITARY MANNER: The facility did not maintain separate sorting of soiled clothing and sanitized laundry. Also laundry equipment including washers, dryer, hampers, plastic containers that are used to sort clothing and transport sanitized clothing from the laundry area had not been routinely cleaned and sanitized. Also the laundry floor, walls and doors where the two washing machines and dryer are placed were not routinely cleaned and sanitized to provide sanitary surfaces for clean laundry to be sorted, folded and stored. During tour of the facility's laundry and linen areas, with the environmental service director on 8/22/13, at 12:40 p.m., the following observations were made: A walking path, which measured approximately four feet by four feet, was used to transport bagged soiled laundry past the two washing	F 441		

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	245376	A. BUILDING _____ B. WING _____	08/23/2013

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 441	Continued From page 57	F 441		

machines and dryer in order to access the hallway. The facility had a contracted linen cleaning service that did all of the common use laundry and linens, while residents personal clothing and items were laundered in the facility. The soiled personal resident laundry was brought into the laundry area from the nursing floors to be sorted for washing.

The laundry room had one dryer, two residential washing machines and one plastic soaking bin which sat on the floor next to the washing machines. The cement wall located directly behind the plastic soaking bin was noted to have a large blackened area.

Four plastic containers, from which the soiled resident laundry had been sorted, were noted to sit on the floor within a few feet of the washers and dryer. All four of the plastic containers had gravel-like debris inside them. During interview with the environment director it was learned that the bins were not routinely sanitized.

The laundry room floor had a layer of debris and the four walls were soiled with debris.

A portable fan was located in laundry room and it had a layer of dust/debris on all fan blades and grid.

The room where cleaned personal laundry was sorted and folded (the sanitized personal laundry was taken from the laundry room with the washers and dryer to another room located down the hallway) there were three plastic bins with cleaned/sanitized personal resident clothing in them and on checking them for cleanliness there was visible debris which looked like sand on the bottom of the bins. The sanitized clothing came in contact with the soiled bins. One bin had a peanut along with debris inside the bottom of the bin.

Again on interview with the environmental director it was learned that these bins are not routinely

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	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 441	Continued From page 58 sanitized. On the west wing nursing unit the clean linen cart was observed to have one shelf located near the sanitized laundry (towels, washcloths and sheets) had two visible coffee or pop ring stains. On the south nursing unit wing linen cart there had been one shelf located near the sanitized laundry that had one coffee or pop ring stain visibly observed. During interview on 8/22/13, at 1:54 p.m., the environmental service director reported that sanitizing/cleaning of the laundry room and equipment had not been done for "a while." He also reported that staff was not to use the linen cart for holding drinks. The environmental service director stated they did not have a cleaning schedule log for the laundry area or a policy for cleaning the laundry area. During interview on 8/23/13, at 9:47 a.m., licensed practical nurse (LPN)-B stated no drinks were to be placed on the linen carts. During interview on 8/23/13, at 9:47 a.m., the director of nursing (DON) stated she expected staff not to set drinks on/in clean linen carts. Review of facility's GENERAL INFORMATION for CARE CENTER LAUNDRY policy, dated 12/05, read, "1. Staff will follow proper infection control procedure for picking up personals via cart. 2. Wearing gloves, staff will sort personals into proper bins based on color and clothing type. 3. Staff will use clean, marked carts for loading and unloading of washer and dryer." Review of facility's LINEN HANDLING POLICY dated 4/10, read, "Personnel must handle, store,	F 441		

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F 441	Continued From page 59 process and transport linens so as to prevent the spread of infection... Keep soiled and clean linen, and their respective hampers and laundry carts, separate at all times... Separate soiled and clean linen at all times... Consider all soiled linen to be potentially infectious." FACILITY FAILED TO ENSURE PERSONAL PROTECTIVE EQUIPMENT (PPE) WAS AVAILABLE WHEN HANDLING SOILED LINENS AND RESIDENT CLOTHING: During tour of the facility's laundry and linen areas, with the environmental service director on 8/22/13, at 12:40 p.m., the following observations were made: The laundry room had a worn discolored white cloth coat hanging on a hook, which the environmental service director stated was for staff to wear when sorting dirty linens and when moving soiled linens in and out of the laundry room. The environmental service director verified the cloth coat was not made of semi-permeable material and staff had potential to be contaminated by soiled laundry. The west wing, north wing and south wing utility rooms located on the resident floor did not have any type of personal protective equipment (gown, coat, etc.) available in the area for staff use when rinsing soiled (with stool or any bodily fluids) linens. On asking the environmental service director about the lack of personal protective equipment he said they do provide gloves and they can go to the laundry cart and get a cloth resident gown. During interview on 8/22/13, at 1:11 p.m., nursing assistant (NA)-A verified she had rinsed soiled linens in the hoppers that were available in the	F 441	**F 441:** In order to gain compliance with tag F 441 Zumbrota Health Services has developed cleaning schedules for areas in laundry which include the cleaning of washing machines, dryer, walls, floor, doors, soiled personal laundry bins, clean laundry bins, and wall fans. Cleaning schedules were developed and implemented on 9/20/2013. All areas mentioned were cleaned and sanitized prior to 9/20/2013. The walls and floor of the laundry room were cleaned and painted prior to 9/20/2013. Semi-permeable gowns have been stocked in laundry room and dirty utility rooms along with gloves and goggles. Environmental Services Director is responsible to ensure cleaning lists are completed .	

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F 441	Continued From page 60 utility rooms. She added that she just wore gloves as personal protective equipment. NA-A reported the staff did not have a gown available for use when rinsing soiled linens. NA-A stated she had been asking for a splash guard to be put on the hoppers for three years to protect them from being soiled when washing soiled laundry. During interview on 8/22/13, at 2:16 p.m., the DON stated staff rinsed linens in the hoppers only when grossly soiled with bowel movement or emesis. DON stated that staff wore gloves only, but could wear a cloth gown if needed. The DON verified the cloth gown did not protect from splash while rinsing soiled linens and no semi-permeable gowns were available for staff use. Review of facility's LINEN HANDLING POLICY dated 4/10, read, "Personnel must handle, store, process and transport linens so as to prevent the spread of infection... The risk of environmental contamination may be reduced by having personnel bag or contain contaminated linen at the point of use, and not sorting or pre-rinsing in resident care areas. The following equipment and supplies will be necessary when performing this procedure. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). 1. Do not allow linen, clean or soiled, to touch clothing or uniform. 2. Handle all soiled linen as though it is potentially infectious." The policy further indicated, "Outside Resident Rooms A. Handle soiled linen as little as possible to prevent agitation when rinsing soiled linen in the soiled utility room. In the Laundry Assemble the equipment and supplies needed Employees sorting or washing linens must wear [as needed] a gown/apron, gloves, and a mask... Wear gown or apron when sorting soiled linen... Keep soiled	F 441	A policy for the storage of reusable equipment has been implemented. Commodes are to be cleaned out and sanitized in a dirty utility room. After being sanitized they are to be brought to a bathing suit for storage until next use. Signs, communication, and reeducation have been done for all staff regarding proper reusable equipment storage. Director of Nursing is responsible to ensure commodes are cleaned and stored per policy. Random audits will be conducted by the DON/designee, daily X 2 weeks, then 3X week X 2 weeks, then weekly thereafter, to ensure proper procedures are being followed relating to commodes. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: Sept 30, 2013.	9/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 441	Continued From page 61 and clean linen, and their respective hampers and laundry carts, separate at all times... Separate soiled and clean linen at all times... Consider all soiled linen to be potentially infectious." FACILITY FAILED TO STORE MULTI-RESIDENT USE COMMODE IN A SANITARY MANNER: During tour of the facility's laundry and linen areas, with the environmental service director on 8/22/13, at 12:40 p.m., the north utility room located on the resident unit was noted to have an entire portable commode sitting on top of the hopper, the legs of the commode were over the edges of the hopper and the bucket of the commode was sitting down in the hopper water, the lid of the commode was closed. At the time observed, environmental service director was unsure why the commode was placed on top of the hopper. During interview on 8/22/13, at 1:11 p.m., NA-A stated the commode was being used for the day for residents and it was where it was stored between resident uses. During interview on 8/23/13, at 9:47 a.m., LPN-B stated staff should not have set the commode on and in the hopper. During interview on 8/23/13, at 9:47 a.m., the DON stated she expected staff not to set the commode on top of the hopper. A policy for storage of reusable equipment was requested from the DON at the time of this interview. However, no policy was provided.	F 441		
F 465	483.70(h)	F 465		

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F 465 SS=F	Continued From page 62 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain laundry equipment in state of good repair to ensure the equipment can be fully sanitized for resident laundry use. This had the potential to affect all 34 of 34 residents who resided in the facility. Findings include: During tour of the laundry room with the environmental service director on 8/22/13, at 12:40 p.m., observation revealed two washing machines that were used to wash personal resident ' s laundry and also used to wash soiled mop heads had visible rust on each washer located on the top rim (located by the bleach dispensing cup). One washing machine was noted with duct tape over the bleach dispensing cup, which had trapped dirt and debris. During interview on 8/22/13, at 12:40 p.m., environmental service director verified the rust areas and duct tape were on the washing machines. The environmental service director verified the washing machines needed repairs prevented the area where clothing touched the machine to be sanitized properly.	F 465	F 465: In order to gain compliance with tag F 465 Zumbrota Health Services replaced one of the washing machines cited in the tag. Environmental Services Director has repaired the second washing machine that was cited on 9/14/2013. Environmental Services Director is responsible to ensure the washing machines remain free of rust and in sanitary working order. Machines will be checked for rust and debris when cleaned according to cleaning schedule. Any noted rust will be immediately reported to Environmental Services Director who will ensure it is promptly removed. Completion date: Sept 30, 2013.	9/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING 01 B. WING _____	C 08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Zumbrota Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED SEP 23 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok TB 9-25-13	

Dc: 10.02.2013

Exit: 08.23.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherman Donahe	Administrator	9/21/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	**433 MILL STREET** **ZUMBROTA, MN 55992**

(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
K 000	Continued From page 1 By e-mail to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Zumbrota Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction, with a partial basement. In 1968, an addition was constructed that was determined to be of Type II(000) construction, with no basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with partial smoke detection in corridor and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 35 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2013**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Surveyor: 25822 Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 35 residents. Findings include: On facility tour between 2:30 PM and 4:30 PM on 08/21/2013, the review of the fire drill documentation for the past 12 months (August 2012 to July 2013) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Day: 1226, 0859, 1210 and 0823 hours Nights: 0400, 2315, 2310 and 2335 hours	K 050	see attachment	9-18-13

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	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2013**

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K 050	Continued From page 3 This deficient practice was confirmed by the Director of Maintenance (RG) and Administrator (SD) at the time of discovery.	K 050		
K 071 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This Standard is not met as evidenced by: Surveyor: 25822 This STANDARD is not met as evidenced by: Based on observations, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and NFPA 82. This deficient practice could affect 35 residents	K 071	See attachment	9-12-13

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K 071	Continued From page 4 Finding include: On facility tour between 2:30 PM and 4:30 PM on 08/21/2013, observation revealed, that the 1st floor soiled linen chute door that is open to the corridor does automatically close. This deficient practice was confirmed by the Director of Maintenance (RG) and Administrator (SD) at the time of discovery.	K 071		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Surveyor: 25822 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has corridor obstructions. These obstructions could interfere with the convenient and effective removal of patients, staff and visitors in an emergency situation. The deficient practice could affect all 35 residents. Findings include: On facility tour between 2:30 PM and 4:30 PM on 08/21/2013, observation revealed, that the installation of the interior finishes in the North,	K 072	See attachment	10-9-13

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	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2013**

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K 072	Continued From page 5 South and West corridors has diminished the width of an existing corridor. The corridors width was reduced from 84-3/4 inches to 75-3/4 inches the entire length of each corridor. This deficient practice was confirmed by the Director of Maintenance (RG) and Administrator (SD) at the time of discovery. NOTE: This deficiency need not be corrected if an FSES can establish that the facility has a level of fire safety equivalent to the required by the Life Safety Code, NFPA 101, 2000 Edition. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 072		

K 050:

In order for Zumbrota Health Services to gain compliance with requirements of 2000 NFPA 101, Section 19.7.1.2. Fire drills will be conducted once per shift per quarter for all staff under varying times and conditions. A fire drill was conducted on 9/18/2013 at 3:30 AM so as to have held a staggered drill on nights. Environmental Services Director will be responsible to ensure that drills are sufficiently staggered on each shift so as to maintain compliance. Dates and times of drills will be planned a year at a time so as to ensure they are properly staggered.

K 071:

In order for Zumbrota Health Services to gain compliance with K 071 the laundry chute door was repaired on September 12th, 2013 and now closes automatically. Additional measures were put into place to prevent future breakage of the self-closing mechanism on the laundry chute door. Environmental Services Director was responsible to ensure the chute door was repaired properly and is responsible to ensure it continues to self-close as required. Environmental Services Director will do weekly checks of the chute door until it is determined by facility that interventions put in place to prevent future breakage of the chute door are effective.

K 072:

In order to gain compliance with K 072 a FSES survey will be conducted at the Zumbrota Care Center. Zumbrota Care Center will achieve a passing FSES score by October 1st, 2013.

9

FS - per attached e-mail

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Wednesday, September 25, 2013 2:38 PM
To: 'Shannon Donahue'
Cc: RImholteFiresafe@aol.com
Subject: RE: POC Extension Request

Shannon – Your request to extend the completion date for K72 to 10-9-13 is acceptable and approved.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

From: Shannon Donahue [mailto:sdonahue@zhs.sfhs.org]
Sent: Wednesday, September 25, 2013 2:28 PM
To: Sheehan, Pat (DPS)
Cc: RImholteFiresafe@aol.com
Subject: POC Extension Request

Mr. Sheehan,

I am writing to request to make an amendment to tag K 072 on the survey results I sent in from our 2013 Life Safety Code Survey. Bob Imholte was onsite yesterday and conducted our FSES survey. We currently have a construction project underway and there were some ceiling tiles that were not in place yesterday due to the electrician pulling wires. Due to the tiles being out we did not achieve a passing score on the FSES survey. In my plan of correction for tag K 072 I stated we would achieve a passing FSES score by 10/01/2013. I would like to request that it be changed to 10/09/2013. The ceiling tiles are set to be in place again prior to 10/09/13. Please let me know if you have further questions for me.

Thank you,

Shannon Donahue
Administrator
Zumbrota Health Services

507-732-8402