DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 10, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: March 23, 2022

Dear Administrator:

On May 5, 2022, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 10, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: Reinspection Results
Event ID: TDF312

Dear Administrator:

On May 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 23, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2022

CMS Certification Number (CCN): 245376

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Dear Administrator:

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 April 30, 2022 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: March 23, 2022

Dear Administrator:

On March 23, 2022, a 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by June 23, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	C 03/23/2022

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
E 000	Initial Comments On 3/21/22 through 3/24/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 3/21/22 through 3/23/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5376033C (MN80515). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 641	Accuracy of Assessments	F 641		4/30/22

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

Electronically Signed | 04/23/2022

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 641 SS=B	Continued From page 1 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for restraints for 4 of 4 residents (R9, R20, R22, R18) when the MDS indicated the use of bed rail restraints when restraints were not being used. Findings include: R9's Resident Face Sheet printed 3/23/22, identified diagnoses including anxiety disorder, dementia without behavioral disturbance and adult failure to thrive. During an observation on 3/21/22, at 2:39 p.m. R9's bed was observed to have two grab bars. R9's significant change Minimum Data Set (MDS) assessment dated 12/31/21 indicated in the MDS section restraints and alarms that R9 used a bed rail daily. R9's medical record was reviewed and lacked any evidence R9's grab bars were used as a restraint. R9's physical restraint care area assessment (CAA) dated 1/7/22 included, "[R9] has bilat [sik] grab bars, less than half the length of the bed, which she uses for positioning and balance during repositioning and care in bed. They do not	F 641	The MDS coordinator modified R9's MDS with ARD of 12/31/21. The modification will include coding item P0100A bed rail as not used. The MDS coordinator modified R20s MDS with ARD of 2/15/22. The modification will include coding item P0100A bed rail as not used. The MDS coordinator modified R22's MDS with ARD of 3/11/22. The modification will include coding item P0100A bed rail as not used. The MDS coordinator modified R28's MDS with ARD of 3/10/22. The modification will include coding item P0100A bed rail as not used. The MDS coordinator was re-educated on accurately coding section P0100A on 3/22/22 by the Director of Quality. All residents who utilize "bed rails" will have section P of their MDS reviewed going back three months for accuracy by the MDS coordinator. MDS audits will be completed by the Administrator or designee, 2 records will be audited per week for 2 weeks then 1 record weekly for 2 weeks, then 2 records per month ongoing for coding accuracy. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	

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F 641	Continued From page 2	F 641		

restrict her vision or ability to get out of bed, enhancing movement in bed ..."

During an interview on 3/23/22, at 10:39 a.m. registered nurse (RN)-A verified R9's significant change MDS dated 1/7/22, was coded as R9 had a bed red that was used daily as a restraint.

R20's Resident Face Sheet printed 3/23/22, identified diagnoses including anxiety disorder, dementia with behavioral disturbance and major depressive disorder.

During an observation on 3/21/22, at 3:01 p.m. R20's bed was observed to have two grab bars.

R20's quarterly Minimum Data Set (MDS) assessment dated 2/15/22 indicated in the MDS section restraints and alarms that R20 used a bed rail daily.

R20's medical record was reviewed and lacked any evidence R20's grab bars were used as a restraint.

R20's General Nurse's Observation dated 11/24/21 included, " ...The resident grabs onto the bars independently when turning and repositioning ...The mobility bars do not impede the resident's freedom of movement or obstruct her view ..."

During an interview on 3/23/22, at 10:39 a.m. RN-A verified R20's quarterly MDS dated 2/15/22, was coded as R22 had a bed red that was used daily as a restraint.

R22's Resident Face Sheet printed 3/23/22,

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F 641	Continued From page 3	F 641		

identified diagnoses including dementia without behavioral disturbance and major depressive disorder.

During an observation on 3/21/22, at 2:34 p.m. R22's bed was observed to have two grab bars.

R22's significant change/5-day Minimum Data Set (MDS) assessment dated 3/11/22, indicated in the MDS section restraints and alarms that R22 used a bed rail daily.

R22's medical record was reviewed and lacked any evidence R22's grab bars were used as a restraint.

R22's physical restraint care area assessment (CAA) dated 2/9/22 included, "[R22] uses mobility bars to assist her with bed mobility and transfers. The bars do not impede her ability to get up from the bed so do not functions as restraints ..."

During an interview on 3/23/22, at 10:39 a.m. RN-A verified R22's significant change/5-day MDS dated 3/11/22, was coded as R22 had a bed red that was used daily as a restraint.

R28's Resident Face Sheet printed 3/23/22, identified diagnoses including bipolar disorder, borderline personality disorder and anxiety disorder, dementia with behavioral disturbance and major depressive disorder.

During an observation on 3/21/22, at 2:37 p.m. R28's bed was observed to have no grab bar or bed rails on her bed.

R28's annual Minimum Data Set (MDS) assessment dated 3/10/22 indicated in the MDS

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F 641	Continued From page 4 section restraints and alarms that R28 used a bed rail daily. R28's medical record was reviewed and lacked any evidence R28 had grab bars or a bed rail. R28's General Nurse's Observation dated 10/1/201 included, " ...She does not have grab bars on her bed and has no interest in them ..." During an interview on 3/23/22, at 10:39 a.m. RN-A verified R28's annual MDS dated 3/10/22 was coded as R28 had a bed red that was used daily as a restraint. RN-A stated she was in error about the definition of a restraint. RN-A stated she thought the mobility rails counted as bed rails, she was just saying there was a bed rail in place for the resident and did not mean to count it as a restraint. RN-A stated she thought she would get into trouble if she did not mark the bed rail. RN-A verified R9, R20, R22 and R28's MDS's were coded in error to reflect restraints. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2019, identified a section labeled, "Section P0100: Physical Restraints" Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.	F 641		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/30/22

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F 812	Continued From page 5 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their hot water temperature dishwasher had hot enough water to sanitize the dishes for all 27 residents who ate food from the kitchen. In addition, the facility failed to ensure perishable food items were discarded when past their expiration dates for 3 of 3 kitchen refrigerators and 1 of 2 walk-in coolers. Also, the facility failed to ensure perishable items were dated, labeled and not stored beyond their expiration date for 1 of 2 dinette refrigerators. Findings include: During observation on 3/21/22, at 1:19 p.m. dietary aide (DA)-A ran a load of dishes through the facility's hot water temperature dishwasher. There was a soap dispenser and a rinse aide piped into the dishwasher. The dishwasher's	F 812	On 3/21/2022 the dietary department started using Sunburst No-BAC detergent and disinfectant according to label directions to disinfect all of the silverware, cups, tableware, and cookware. The disinfecting protocol and alerting maintenance immediately is in place and to be utilized anytime dish machine temperatures do not reach 160 F. Dietitian educated dietary staff to test dishwasher temperature after each meal and before running dirty dishes. Staff were re-educated on proper dishwasher temperatures and to use dishwasher temperature log as their guide. Dish machine temperature audits will be completed by the Administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure	

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F 812	Continued From page 6 thermometer did not read throughout the wash. DA-A stated the thermometer had been broken for about a month. Instead, they relied on a dishwasher thermometer disc, which was placed on the rack and run through a few times a day to ensure the hot water reached an appropriate level. DA-A ran a rack of dishes through and the thermometer read 122 degrees Fahrenheit (F). A second load ran at 128 degrees F. DA-A stated an earlier load had read at 130 degrees. DA-A stated 120 degrees was how hot it needed to be. A label on the machine identified if using hot water to sanitize, the temperature needed to reach 180 degrees for final sanitizing rinse minimum and rinse tank minimum temperature should be 160 degrees. Therefore, the temperature the thermometer should read when placed on the rack would be a minimum of 160 degrees. DA-A did not know why the label indicated their thermometer should read 160 degrees. DA-A was shown a Dishwasher Temperature Log, which was posted on the wall and indicated the minimum temperature for the dishwasher should be at least 160 degrees. DA-A stated it only needed to be 120 degrees. DA-A stated the dishes which had just been run through the machine belonged to their assisted living and not the skilled nursing facility. The soap and rinse aide which were piped into the dish machine were noted to be, Sunburst Applause Heavy Duty Warewash detergent and Sparkle drying agent. Neither contained any chemical sanitizer, which was verified by DA-A. The Dishwasher Temperature Log for March 2022, identified a final rinse temperature below 160 3 times, each on the evening shift. During an observation on 3/21/22, at 1:56 p.m.	F 812	compliance. This will include documenting a corrective action process if dish machine temperatures are below required levels. The monitoring results will be reported at the quarterly QAPI for review and recommendations for ongoing auditing. 3/21/22 – General Parts were called for repairs on dish machine. On 4/6/22, General Parts arrived on site to start repairs on dish machine. On 4/7/22, Dalco Sunburst Chemical service technician serviced the dish machine by adjusting the heat booster. Still waiting for repair on dish machine gasket. On 4/13/22, General Parts arrived on site to continue repairs on dish machine. On 4/18/22, Dalco Sunburst Chemical service technician, tested dish machine. On inspection, dish machine temperatures were tested three times and results were 160, 161 and 166 at 12:15pm. On 4/20/22, a policy was reviewed and revised on dish machine use and compliance with safety temperatures guidelines. An additional policy was created for manual dish washing. On 4/21/22, the revised dish machine policy was distributed to staff. The policy will be posted on communication bulletin board directly above the dish machine temperature log. On 3/22/22 all outdated foods were removed from the dinette kitchen refrigerator and freezer. On 3/22/22 dietitian checked dry storage	

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F 812	Continued From page 7 the dirty dishes from the skilled nursing facility (SNF) dining room were brought to the dirty dish area. DA-B ran the plates, divided plates, bowls and cups through the dishwasher. The temperature read 137.8 degrees. DA-B stated the dishwasher was a high temperature dishwasher and the 137.8 degrees was a good temperature. The dishes were placed on drying rack and at 2:18 p.m. were delivered by DA-A to the kitchenette on the nursing floor and plates were placed in a plate dispenser and cups into a cupboard. When interviewed on 3/21/22, at 1:58 p.m. the dietician stated the dishwasher was a hot water temperature dishwasher and was not aware of any concerns about the temperature getting hot enough to sanitize the dishes. When interviewed on 3/22/22, at 4:20 p.m. Cook-A stated the dishwasher temperature should reach 160 degrees and if it did not, they should not use the dishes and would notify maintenance. Cook-A was not aware of any concerns with the dishwasher temperatures, but knew a part had been ordered for the temperature gauge. During an observation on 3/21/22, at 5:04 p.m. the evening meal was brought to the kitchenette and placed on the steam table. At 5:12 p.m. cook-A removed the cover from the plate server and started serving food on the un-sanitized plates. The service was stopped by the surveyor. The dietician stated they would normally serve on the unsanitized dishes, as they have no other way to sanitize the dishes. The dietician was unaware the dishwasher had not been working properly. The dietician stated the facility does not have a	F 812	for outdated product. Two products were found that were beyond Best By date. Items were removed. Upon receiving CMS 2567 report on 4/15/22, more items were listed as being expired. The dietitian immediately notified staff to have these items removed from the kitchen refrigerator and walk-in cooler. All staff were re-educated on proper food storage guidelines, proper labeling of food and discarding of outdated products. On 4/20/22, the following policies were reviewed and edited as needed: Perishable Food Storage Policy, Non-Perishable Food Storage Policy, and Cooling Food Policy. Administrator or designee will complete stored food audits 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	

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	245376	A. BUILDING _____ B. WING _____	C 03/23/2022

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F 812	Continued From page 8	F 812		

three compartment sink or any way to sanitize the dishes, then directed staff to use paper plates for this service.

When interviewed on 3/21/22, at 5:42 p.m. maintenance (M)-A stated he was not aware the dishwasher in the kitchen was broken and that his environmental service director (ESD) would have record of anything broken down in facility. M-A did not know if there were any logs of things needing repair and that he was just told in verbal report what needed to be done.

When interviewed on 3/21/22, at 6:02 p.m. the dietician stated the yellow disk thermometer tested the highest overall temperature of the water. The dietician stated the temperature should reach 160 degrees F with plate guard and 180 degrees F without it. The dietician stated the facility checks the temperatures after every meal and should be 160 degrees F. The dishwasher had been broken for a couple of weeks and it had been, "iffy." Dietary staff were to inform the environmental services director (ESD) and M-A if anything breaks down in the kitchen.

When interviewed on 3/21/22, at 5:50 p.m. the administrator stated she did not know anything about a broken dishwasher and it was the first time finding out about it. The administrator stated ESD checks hot water temperatures during the day and handles all of repairs and ordering parts for facility.

When interviewed on 3/22/22, at 12:50 p.m. the dietician stated they had started using Sunburst No-BAC detergent and disinfect according to label directions to disinfect all of the silverware, cups, table ware as well as pots/pans. They

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sanitized all of the dishes last night and have a protocol in place until a sanitizing agent can be added to the dishwasher cycle.

When interviewed on 3/22/22, at 1:37 p.m. the ESD produced multiple receipts for the dishwasher repair. The heater and electric wiring had been repaired 4 times since 2019. The last time the heater was replaced was on 2/4/22. A new heater/temperature gauge was ordered on 3/2/22, and were on back order. The ESD did not know how the kitchen sanitized dishes while waiting for parts/repair.

When interviewed on 3/23/22, at 11:40 a.m. the administrator stated they did not have any policies related to the dishwasher or sanitizing dishes.

During an observation with cook-A on 3/21/22, at 12:48 p.m. the following items were noted to be expired and not labeled correctly in kitchen refrigerators:
-opened ham stock base expired on 6/25/19; handwritten date of 1/12 (no year).
-opened chicken stock base expired on 4/9/20; handwritten date of 10/22 (no year).
-opened turkey stock base expired on 9/17/21; no handwritten date on container when opened.
-opened roasted garlic base expired on 9/16/21; handwritten date 11/19 (no year).
-opened beef stock base handwritten date 9/2 (no year).
-opened vegetable stock base expired on 3/15/21; handwritten date of 6/3 (no year).
-opened buttermilk ranch best used by dated 10/14/21; no handwritten date on container when opened.
-opened unknown luncheon meat dated 3/4 and

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3/6 (no year).
-unopened bologna with use by date of 12/23/21.
-unopened hard boiled eggs with use by date 3/16/22.

When interviewed on 3/21/22, at 1:00 p.m. cook-A confirmed the stock bases get used at least twice weekly. She verified opened items in refrigerator were expired and facility uses stock bases at least twice weekly. C-A stated facility's food supplier is Upper Lakes and sometimes receives expired foods. She was unable to state if the supplier took the expired food delivered back or not.

During an observation on 3/21/22, at 1:15 p.m. the following items were noted to be expired in the walk in cooler:
-chicken base stock expired on 7/21/20
-roasted garlic base expired on 9/16/21

When interviewed on 3/21/22, at 1:20 p.m. cook-B stated, food should be dated when the supplier delivers it and again when opened by dietary staff.

During an observation on 3/21/22, 2:34 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette kitchen refrigerator:
-undated and unlabeled slice of pie in door.
-R10 undated and unlabeled French toast sticks in door.
-opened ketchup expired on 11/28/21 in door.
-opened herring cutlets with mold
-opened blue cheese salad dressing expired on 3/15/21 in door.
-R23 opened redi whip expired 10/2021; handwritten opened date 6/7 (no year).

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-opened buffalo sauce with no expiration date or date opened.
-opened smoothie from next step nutrition with straw; 80% drank, no name or date.

During an observation on 3/21/22, at 2:34 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette kitchen freezer:
-opened Tom & Jerry's ice cream expired on 6/23/21; unlabeled.
-opened Blue Bunny ice cream expired on 3/13/22.
-R10 undated and unlabeled French toast sticks in door.

When interviewed on 3/22/22, 9:44 a.m. C-B stated the expired food had been removed and discarded.

A policy for rotating food inventory, or expired food was requested, but not provided by the facility.

A Food and Drug Administration (FDA) Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that

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F 812	Continued From page 12 use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization."	F 812		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/22/2022. At the time of this survey, ZUMBROTA CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/23/2022

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ZUMBROTA CARE CENTER is a one-story building, with a partial basement The building was constructed at (3) 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 and was determined to be of Type II (000) construction, with no basement. Finally, in 2014 a 2-story addition was constructed and was determined to be of Type II	K 000		

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K 000	Continued From page 2 (000) construction, with no basement. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		4/30/22

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K 324	Continued From page 3 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to provide confirming documentation that the Ansul type fire extinguishing equipment is being tested and maintained per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 9.2.3, NFPA 96 (2012 edition) Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2, and NFPA 17A (2009 edition) Standard for Wet Chemical Extinguishing Systems, section 7.5. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that was presented for review identified that the six-month required interval inspection of the Ansul type fire extinguishing equipment system was past due as it should have been completed on or before 02/02/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	The Ansul type fire extinguishing equipment inspection was held on 3/28/2022 and passed. Maintenance will pre-book 6 month inspections in advance. Maintenance to call one month prior to inspection to confirm the 6 month pre-booked date. Administrator or designee will audit to ensure that the 6 month inspection occurs on time. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		4/30/22

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K 353	Continued From page 4 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that in the Basement - Kitchen, and Dishwashing Areas,	K 353	1.The kitchen and dishwashing area sprinkler heads that exhibited signs of oxidation were changed on 3/29/2022. Sprinkler head audits will be completed by Maintenance or designee every 6 months to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations of ongoing monitoring. 2.Cabling that was attached to the sprinkler system in the mill boiler room was removed on 3/23/2022. Maintenance audited the sprinkler system to ensure that no additional cabling was attached to the sprinkler system on 3/23/2022. When contractors that are running cabling enter	

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K 353	Continued From page 5 sprinkler heads exhibited signs of oxidation. 2. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that in the Basement - Mill Boiler Room, that cabling was attached to the sprinkler system. 3. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that in the Basement - Auxiliary Elevator Room, that cabling was attached to the sprinkler system. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	the building maintenance will inform them that cabling cannot be attached to the sprinkler system and will audit before they leave. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. 3.Cabling that was attached to the sprinkler system in the auxiliary elevator room was removed on 3/23/2022. Maintenance audited the sprinkler system to ensure that no additional cabling was attached to the sprinkler system on 3/23/2022. When contractors that are running cabling enter the building maintenance will inform them that cabling cannot be attached to the sprinkler system and will audit before they leave. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374		4/30/22

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K 374	Continued From page 6 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that upon testing of the 1st floor - W Wing that the smoke barrier door assembly did not self-close resisting the passage of smoke. 2. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that upon testing of the 1st floor - Dining Room smoke barrier door assembly, they exhibited an air gap greater than 1/8 inch. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 374	1.The 1st floor – west wing smoke barrier door assembly was fixed on 3/24/2022 so that it self closes to resist the passage of smoke. Smoke barrier door audits will be completed by Maintenance or designee monthly for 3 months to ensure alignments don't slip back out of compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. 2.The 1st floor – dining room smoke barrier door assembly was fixed on 3/24/2022 to correct the air gap that was greater than 1/8 inch. Smoke barrier door audits will be completed by Maintenance or designee monthly for 3 months to ensure alignments don't slip back out of compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations of ongoing monitoring.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.	K 511		4/30/22

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	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

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K 511	Continued From page 7 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation in the area of the Basement - Auxiliary Elevator Room that access to the electrical panels existed was obstructed. 2. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation in the area of the Basement - Biohazard Storage Room that access to the electrical panels existed was obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	1.The item/s that were obstructing the electrical panels in the basement auxiliary elevator room were removed on 3/22/2022 so that the electrical panels are easy to access. Electrical panel audits will be completed by the Administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. 2.The item/s that were obstructing the electrical panels in the biohazard storage room were removed on 3/22/2022 so that the electrical panels are easy to access. Electrical panel audits will be completed by the Administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712		4/30/22

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K 712	Continued From page 8 signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4, 19.7.1.6, 4.7.2, and 4.7.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire drill had been conducted for 1st shift - 4th quarter 2021, and for 2nd shift - 2nd quarter 2021. 2. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed during documentation review that the fire drill reports presented for review revealed drills were not varied by times and conditions in the calendar dates on which drills were conducted. a. 1st shift - 2nd and 3rd quarter drills were conducted on the same calendar date - 27th b. 3rd shift - 2nd, 3rd, and 4th quarter drills were	K 712	1.No documentation available or presented for review to confirm that fire drills had been conducted for 2nd shift – 2nd quarter or 1st shift – 4th quarter 2021. Administrator and Maintenance will ensure that documentation for each fire drill conducted will be placed in the Life Safety Code binder. Fire drill documentation audits will be completed by the Administrator or designee 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. 2.The fire drill reports reviewed, revealed that drills were not conducted by varied times and conditions in the calendar dates. Administrator and Maintenance will schedule fire drills at varied times and calendar dates each month. Fire drill documentation audits will be completed by the Administrator or designee 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing	

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K 712	Continued From page 9 conducted on the same calendar date - 30th c. 9 of 10 documented fire drills were conducted in the last week of each respective quarter d. 8 of 10 documented fire drills exhibited shift-to-shift timestamp separation of less than 60-minutes - quarter-to-quarter. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	monitoring.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire door assemblies per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 19.3.6.3.5, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2. This deficient finding could have an isolated impact on the residents within the facility.	K 761	The basement kitchen/dishwasher fire doors that did not self-close, sealing the opening were fixed on 3/24/2022. Fire door audits will be completed by Maintenance or designee monthly for 3 months to ensure alignments don't slip back out of compliance. The auditing results will be reported at the quarterly	4/30/22

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K 761	Continued From page 10 Findings include: On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that upon testing the Basement - Kitchen / Dishwasher fire doors, they did not self-close, sealing the opening. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	QAPI meetings for recommendations and ongoing monitoring.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 914	Maintenance received the LLSC Form	4/30/22

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K 914	Continued From page 11 and staff interview, the facility failed to record electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.4, 6.3.4.2.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that the documentation presented for review did not clearly identify or provide confirmation that the physical condition, ground continuity, polarity, and ground retention force of the individual outlets in resident rooms had been completed. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 914	4o2 to document the electrical receptacle testing in the resident rooms confirming the physical condition, ground continuity, polarity, and ground retention force of the individual outlets has been completed. Maintenance will be testing all resident room receptacles the week of April 25th – 29th 2022. Resident room electrical receptacle audits will be completed by the Administrator or designee on 4/30/22 to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum	K 923		4/30/22

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K 923	Continued From page 12 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 5.1.3.3.4, 5.1.3.3.4.1, 11.3, 11.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.2.3(3), 11.6.5, NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluids Code, sections 7.1.4.2.1, 7.1.8.4, 7.1.8.1, 7.1.8.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that on the 1st	K 923	1&2.Med Gas storage areas in the facility are less than or equal to 300 cubic feet. a.Signage has been placed within the utility room corridors to provide an indication that Med Gas is being stored within the rooms or secondary rooms. b.Signage has been placed within the utility rooms, on the door of the secondary rooms to indicate that Med Gas is being stored within the rooms. c.Signage has been placed to identify the location of empty/full cylinders in each location. d.The Med Gas room on the west hall has been secured.	

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K 923	Continued From page 13 floor - W Wing that the Med Gas Room was a storage room inside of the Utility Room. a. No identifying signage was observed on the Utility Room corridor door to provide an indication that Med Gas was being stored within the room -or- secondary room b. No identifying signage was observed within the Utility Room, on the door of the secondary room being used as a Med Gas Room c. Within the Med Gas Room - there was no signage to identify the location of empty/full cylinders d. The Med Gas Room was found to be unsecured 2. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that the W Wing Utility Room has a secondary room that is in use as a Med Gas Room. The Utility Room door the interfaces the corridor did not have identifying signage that Med Gas was being stored within. The secondary room actually being used as the Med Gas Room lacked signage on the door, had no distinguishable separation of cylinders in the room, and there was no in-room signage to identify locations for empty/full cylinders. 3. On 03/22/2022, between 09:00 AM to 01:00 PM, it was revealed by observation that on the 1st floor in the Beauty Shop, a Med Gas e-cylinder was being stored. Per information provided by facility staff, oxygen is not allowed in the Beauty Shop. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	Med Gas storage audits will be completed by the Administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. 3.The Med Gas cylinder located in the beauty shop has been removed and placed in the north hall Med Gas room. Signage has been placed on the beauty shop door and in the room indicating that oxygen cannot be used or stored in the beauty shop. Med Gas audits will be completed by the Administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders
Event ID: TDF311

Dear Administrator:

The above facility was surveyed on March 21, 2022 through March 23, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Please 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.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: _____ B. WING _____	C 03/23/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/21/22 through 3/23/22, a licensing survey and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be UNSUBSTANTIATED: H5376033C (MN80515). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for restraints for 4 of 4 residents (R9, R20, R22, R18) when the MDS indicated the use of bed rail restraints when restraints were not being used. Findings include: R9's Resident Face Sheet printed 3/23/22, identified diagnoses including anxiety disorder, dementia without behavioral disturbance and adult failure to thrive. During an observation on 3/21/22, at 2:39 p.m. R9's bed was observed to have two grab bars. R9's significant change Minimum Data Set (MDS)	2 550	Corrected	4/30/22

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	00917	A. BUILDING: _____ B. WING _____	C 03/23/2022

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2 550	Continued From page 3 assessment dated 12/31/21 indicated in the MDS section restraints and alarms that R9 used a bed rail daily. R9's medical record was reviewed and lacked any evidence R9's grab bars were used as a restraint. R9's physical restraint care area assessment (CAA) dated 1/7/22 included, "[R9] has bilat [sik] grab bars, less than half the length of the bed, which she uses for positioning and balance during repositioning and care in bed. They do not restrict her vision or ability to get out of bed, enhancing movement in bed ..." During an interview on 3/23/22, at 10:39 a.m. registered nurse (RN)-A verified R9's significant change MDS dated 1/7/22, was coded as R9 had a bed red that was used daily as a restraint. R20's Resident Face Sheet printed 3/23/22, identified diagnoses including anxiety disorder, dementia with behavioral disturbance and major depressive disorder. During an observation on 3/21/22, at 3:01 p.m. R20's bed was observed to have two grab bars. R20's quarterly Minimum Data Set (MDS) assessment dated 2/15/22 indicated in the MDS section restraints and alarms that R20 used a bed rail daily. R20's medical record was reviewed and lacked any evidence R20's grab bars were used as a restraint. R20's General Nurse's Observation dated	2 550		

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2 550	Continued From page 4 11/24/21 included, " ...The resident grabs onto the bars independently when turning and repositioning ...The mobility bars do not impede the resident's freedom of movement or obstruct her view ..." During an interview on 3/23/22, at 10:39 a.m. RN-A verified R20's quarterly MDS dated 2/15/22, was coded as R22 had a bed red that was used daily as a restraint. R22's Resident Face Sheet printed 3/23/22, identified diagnoses including dementia without behavioral disturbance and major depressive disorder. During an observation on 3/21/22, at 2:34 p.m. R22's bed was observed to have two grab bars. R22's significant change/5-day Minimum Data Set (MDS) assessment dated 3/11/22, indicated in the MDS section restraints and alarms that R22 used a bed rail daily. R22's medical record was reviewed and lacked any evidence R22's grab bars were used as a restraint. R22's physical restraint care area assessment (CAA) dated 2/9/22 included, "[R22] uses mobility bars to assist her with bed mobility and transfers. The bars do not impede her ability to get up from the bed so do not functions as restraints ..." During an interview on 3/23/22, at 10:39 a.m. RN-A verified R22's significant change/5-day MDS dated 3/11/22, was coded as R22 had a bed red that was used daily as a restraint. R28's Resident Face Sheet printed 3/23/22,	2 550		

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2 550	Continued From page 5 identified diagnoses including bipolar disorder, borderline personality disorder and anxiety disorder, dementia with behavioral disturbance and major depressive disorder. During an observation on 3/21/22, at 2:37 p.m. R28's bed was observed to have no grab bar or bed rails on her bed. R28's annual Minimum Data Set (MDS) assessment dated 3/10/22 indicated in the MDS section restraints and alarms that R28 used a bed rail daily. R28's medical record was reviewed and lacked any evidence R28 had grab bars or a bed rail. R28's General Nurse's Observation dated 10/1/201 included, " ...She does not have grab bars on her bed and has no interest in them ..." During an interview on 3/23/22, at 10:39 a.m. RN-A verified R28's annual MDS dated 3/10/22 was coded as R28 had a bed red that was used daily as a restraint. RN-A stated she was in error about the definition of a restraint. RN-A stated she thought the mobility rails counted as bed rails, she was just saying there was a bed rail in place for the resident and did not mean to count it as a restraint. RN-A stated she thought she would get into trouble if she did not mark the bed rail. RN-A verified R9, R20, R22 and R28's MDS's were coded in error to reflect restraints. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2019, identified a section labeled, "Section P0100: Physical Restraints" Physical restraints are any manual method or physical or mechanical	2 550		

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2 550	Continued From page 6 device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable procedures and policies to ensure the timely and accurate capture of resident information pertaining to the Minimum Data Set (MDS); then educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure perishable food items were discarded when past their expiration dates for 3 of 3 kitchen refrigerators and 1 of 2 walk-in coolers. Also, the facility failed to ensure perishable items were dated, labeled and not stored beyond their expiration date for 1 of 2 dinette refrigerators. Findings include: During an observation with cook-A on 3/21/22, at	21100	Corrected	4/30/22

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21100	Continued From page 7 12:48 p.m. the following items were noted to be expired and not labeled correctly in kitchen refrigerators: -opened ham stock base expired on 6/25/19; handwritten date of 1/12 (no year). -opened chicken stock base expired on 4/9/20; handwritten date of 10/22 (no year). -opened turkey stock base expired on 9/17/21; no handwritten date on container when opened. -opened roasted garlic base expired on 9/16/21; handwritten date 11/19 (no year). -opened beef stock base handwritten date 9/2 (no year). -opened vegetable stock base expired on 3/15/21; handwritten date of 6/3 (no year). -opened buttermilk ranch best used by dated 10/14/21; no handwritten date on container when opened. -opened unknown luncheon meat dated 3/4 and 3/6 (no year). -unopened bologna with use by date of 12/23/21. -unopened hard boiled eggs with use by date 3/16/22. When interviewed on 3/21/22, at 1:00 p.m. cook-A confirmed the stock bases get used at least twice weekly. She verified opened items in refrigerator were expired and facility uses stock bases at least twice weekly. C-A stated facility's food supplier is Upper Lakes and sometimes receives expired foods. She was unable to state if the supplier took the expired food delivered back or not. During an observation on 3/21/22, at 1:15 p.m. the following items were noted to be expired in the walk in cooler: -chicken base stock expired on 7/21/20 -roasted garlic base expired on 9/16/21	21100		

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21100	Continued From page 8 When interviewed on 3/21/22, at 1:20 p.m. cook-B stated, food should be dated when the supplier delivers it and again when opened by dietary staff. During an observation on 3/21/22, 2:34 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette kitchen refrigerator: -undated and unlabeled slice of pie in door. -R10 undated and unlabeled French toast sticks in door. -opened ketchup expired on 11/28/21 in door. -opened herring cutlets with mold -opened blue cheese salad dressing expired on 3/15/21 in door. -R23 opened redi whip expired 10/2021; handwritten opened date 6/7 (no year). -opened buffalo sauce with no expiration date or date opened. -opened smoothie from next step nutrition with straw; 80% drank, no name or date. During an observation on 3/21/22, at 2:34 p.m. the following items were noted to be undated, unlabeled, and expired in the dinette kitchen freezer: -opened Tom & Jerry's ice cream expired on 6/23/21; unlabeled. -opened Blue Bunny ice cream expired on 3/13/22. -R10 undated and unlabeled French toast sticks in door. When interviewed on 3/22/22, 9:44 a.m. C-B stated the expired food had been removed and discarded. A policy for rotating food inventory, or expired food was requested, but not provided by the	21100		

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21100	Continued From page 9 facility. SUGGESTED METHOD OF CORRECTION: The dietary director or designee could review and revise policies related to food storage, educate staff, then conduct audits to ensure compliance. The dietary director can bring to the facility's quality assurance meeting. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21160	MN Rule 4658.0675 Subp. 6 Mechanical Cleaning and Sanitizing; Hot Water Subp. 6. Hot water sanitization. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their hot water temperature dishwasher had hot enough water to sanitize the dishes for all 27 residents who ate food from the kitchen. Findings include:	21160	Corrected	4/30/22

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21160	Continued From page 10 During observation on 3/21/22, at 1:19 p.m. dietary aide (DA)-A ran a load of dishes through the facility's hot water temperature dishwasher. There was a soap dispenser and a rinse aide piped into the dishwasher. The dishwasher's thermometer did not read throughout the wash. DA-A stated the thermometer had been broken for about a month. Instead, they relied on a dishwasher thermometer disc, which was placed on the rack and run through a few times a day to ensure the hot water reached an appropriate level. DA-A ran a rack of dishes through and the thermometer read 122 degrees Fahrenheit (F). A second load ran at 128 degrees F. DA-A stated an earlier load had read at 130 degrees. DA-A stated 120 degrees was how hot it needed to be. A label on the machine identified if using hot water to sanitize, the temperature needed to reach 180 degrees for final sanitizing rinse minimum and rinse tank minimum temperature should be 160 degrees. Therefore, the temperature the thermometer should read when placed on the rack would be a minimum of 160 degrees. DA-A did not know why the label indicated their thermometer should read 160 degrees. DA-A was shown a Dishwasher Temperature Log, which was posted on the wall and indicated the minimum temperature for the dishwasher should be at least 160 degrees. DA-A stated it only needed to be 120 degrees. DA-A stated the dishes which had just been run through the machine belonged to their assisted living and not the skilled nursing facility. The soap and rinse aide which were piped into the dish machine were noted to be, Sunburst Applause Heavy Duty Warewash detergent and Sparkle drying agent. Neither contained any chemical sanitizer, which was verified by DA-A.	21160		

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21160	Continued From page 11 The Dishwasher Temperature Log for March 2022, identified a final rinse temperature below 160 3 times, each on the evening shift. During an observation on 3/21/22, at 1:56 p.m. the dirty dishes from the skilled nursing facility (SNF) dining room were brought to the dirty dish area. DA-B ran the plates, divided plates, bowls and cups through the dishwasher. The temperature read 137.8 degrees. DA-B stated the dishwasher was a high temperature dishwasher and the 137.8 degrees was a good temperature. The dishes were placed on drying rack and at 2:18 p.m. were delivered by DA-A to the kitchenette on the nursing floor and plates were placed in a plate dispenser and cups into a cupboard. When interviewed on 3/21/22, at 1:58 p.m. the dietician stated the dishwasher was a hot water temperature dishwasher and was not aware of any concerns about the temperature getting hot enough to sanitize the dishes. When interviewed on 3/22/22, at 4:20 p.m. Cook-A stated the dishwasher temperature should reach 160 degrees and if it did not, they should not use the dishes and would notify maintenance. Cook-A was not aware of any concerns with the dishwasher temperatures, but knew a part had been ordered for the temperature gauge. During an observation on 3/21/22, at 5:04 p.m. the evening meal was brought to the kitchenette and placed on the steam table. At 5:12 p.m. cook-A removed the cover from the plate server and started serving food on the un-sanitized plates. The service was stopped by the surveyor. The dietician stated they would normally serve on	21160		

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21160	Continued From page 12 the unsanitized dishes, as they have no other way to sanitize the dishes. The dietician was unaware the dishwasher had not been working properly. The dietician stated the facility does not have a three compartment sink or any way to sanitize the dishes, then directed staff to use paper plates for this service. When interviewed on 3/21/22, at 5:42 p.m. maintenance (M)-A stated he was not aware the dishwasher in the kitchen was broken and that his environmental service director (ESD) would have record of anything broken down in facility. M-A did not know if there were any logs of things needing repair and that he was just told in verbal report what needed to be done. When interviewed on 3/21/22, at 6:02 p.m. the dietician stated the yellow disk thermometer tested the highest overall temperature of the water. The dietician stated the temperature should reach 160 degrees F with plate guard and 180 degrees F without it. The dietician stated the facility checks the temperatures after every meal and should be 160 degrees F. The dishwasher had been broken for a couple of weeks and it had been, "iffy." Dietary staff were to inform the environmental services director (ESD) and M-A if anything breaks down in the kitchen. When interviewed on 3/21/22, at 5:50 p.m. the administrator stated she did not know anything about a broken dishwasher and it was the first time finding out about it. The administrator stated ESD checks hot water temperatures during the day and handles all of repairs and ordering parts for facility. When interviewed on 3/22/22, at 12:50 p.m. the dietician stated they had started using Sunburst	21160		

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21160	Continued From page 13 No-BAC detergent and disinfect according to label directions to disinfect all of the silverware, cups, table ware as well as pots/pans. They sanitized all of the dishes last night and have a protocol in place until a sanitizing agent can be added to the dishwasher cycle. When interviewed on 3/22/22, at 1:37 p.m. the ESD produced multiple receipts for the dishwasher repair. The heater and electric wiring had been repaired 4 times since 2019. The last time the heater was replaced was on 2/4/22. A new heater/temperature gauge was ordered on 3/2/22, and were on back order. The ESD did not know how the kitchen sanitized dishes while waiting for parts/repair. When interviewed on 3/23/22, at 11:40 a.m. the administrator stated they did not have any policies related to the dishwasher or sanitizing dishes. SUGGESTED METHOD OF CORRECTION: The dietary director or designee could review and revise policies as needed and educate staff. They then could conduct audits to ensure the dishwasher it sanitizing dishes appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21160		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines	21426		4/30/22

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21426	Continued From page 14 issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on an employee positive tuberculosis (TB) test result to include a medical evaluation to rule out active TB and failed to prevent the staff from working with residents until active TB was ruled out, for 1 of 5 staff (NA)-A reviewed for TB screening. Findings include: The facility policy titled, Employee Tuberculosis Prevention and Control dated 7/1/19, included, all employees would have a TB skin test or a T-Spot (IGRA- Interferon Gamma Release Assay- blood test to detect TB) at the time of hire. The IGRA results must be received before working with residents. Nursing assistant (NA)-A's Baseline TB	21426	Corrected	

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21426	Continued From page 15 Screening Tool for Health Care Workers identified a symptom screening and TB blood test was completed on 2/10/22. NA-A's Quest Diagnostics test result form identified the blood sample was received on 2/11/22, and approved on 2/13/22. The test results was identified as POSITIVE. The report explained a positive test did not rule in active TB infection and should be confirmed by other tests such as a sputum smear and culture, PCR and chest radiography. The nursing schedule identified NA-A had worked with residents 19 times since the positive test had been received on 2/13/22. When interviewed on 3/23/22, at 12:50 p.m. the director of nursing (DON) stated, human resources receives the TB blood test results, NA-A's test results should have been reviewed by a nurse, but had been filed away in NA-A's employee health record with no review by a nurse. The positive result had just been brought to her attention when the surveyor requested results. The DON stated NA-A had worked 19 shifts since testing positive and would have a medical evaluation today. When interviewed on 3/23/22, at 1:25 p.m. human resources (HR)-A stated, she had never been told a nurse needed to review the results of employee TB blood test results and had not been instructed on what to do if a test came back positive. SUGGESTED METHOD OF CORRECTION: The infection control preventionist nurse (ICP), director of nursing (DON) and/or designee could	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued From page 16 review policies and procedures related to the screening and testing for tuberculosis for employees. Facility staff could be educated on the TB regulations. The ICP, DON and/or designee could audit for compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME FRAME FOR CORRECTION: 7 DAYS	21426		