



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 26, 2025

Administrator
Zumbrota Care Center
433 MILL STREET
ZUMBROTA, MN 55992

RE: CCN: 245376
Cycle Start Date: August 7, 2025

Dear Administrator:

On August 25, 2025, we informed you that we may impose enforcement remedies.

On September 15, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K353 - Sprinkler System - Maintenance and Testing

K541 - Rubbish Chutes, Incinerators, and Laundry Chutes

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 11, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 11, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two

years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 7, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Zumbrota Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 7, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 7, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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



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Electronically delivered

August 25, 2025

Administrator
Zumbrota Care Center

433 MILL STREET
ZUMBROTA, MN 55992

RE: CCN:245376

Cycle Start Date: August 7, 2025

Dear Administrator:

On August 7, 2025, 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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 November 7, 2025 (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 February 7, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 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	
E0000	Initial Comments On 8/5/25 to 8/7/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.		E0000			09/12/2025	
F0000	INITIAL COMMENTS On 8/5/25 to 8/7/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53761349C (iQIES #1162787, MN00107459). NO deficiencies were cited. 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 substantial compliance with the regulations has been attained.		F0000			09/02/2025	
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and		F0582	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident has had financial situation discussed with his POA. A financial form was filled out and gone over with the family.		09/12/2025	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 55992			
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F0582 SS = D	Continued from page 1 when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by:			F0582	Continued from page 1 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. Resident records were reviewed for the past three months to determine if any other residents SNF ABN's were missed. (June, July, August 2025). None were. In the future, a spreadsheet was created to track when residents will need notification and the HUC put in charge of monitoring this. ZHS policy, and the 10055 SNF ABN form was reviewed along with the instructions for filling it out with the HUC and DON. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Training for the new Social Worker Designee will happen the week of 9/8/25. The Social Worker Designee will review with the HUC on a weekly basis, which residents need notifications given. The Director of Nursing will audit the records once per month for three months. The process will be reviewed at the next quarterly QAPI in late October meeting to determine how long the audits need to continue. The date that each deficiency will be corrected. 09/12/25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 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	
F0582 SS = D	Continued from page 2 Based on interview and document review, the facility failed to provide completed Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN CMS 1005) to 1 of 3 residents (R6) reviewed whose Medicare Part A coverage ended and then remained in the facility. Finding include: R6's census record indicated R6's payer source changed to private pay on 5/23/25 and R6 remained in the facility. R6's face sheet indicated R6's primary payer source is "private pay" with a secondary payer source as "Medicare B". R6's Notice of Medicare Non-coverage (NOMNC) form indicated R6's last covered day was 5/22/25. The form indicated "verbal consent" was obtained from R6's responsible party on 5/19/25. The form was signed by the responsible party on 5/22/25. R6's medical record lacked evidence a SNFABN form had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. During an interview on 8/06/25 at 1:48 p.m., R6's responsible party (FM)-A confirmed R6 was private pay. FM-A confirmed receipt and signing of NOMNC indicating R6's Medicare part A benefits were ending. FM-A stated they did not recall discussing the potential cost of continuing services or completing a SNFABN form. During an interview on 8/6/25 at 1:50 p.m., social services director (SS)-A stated she provides the NOMNC to the beneficiary/responsible party and explains the right to appeal. SS-A stated she was unaware of the SNFABN form and had not been providing them. SS-A confirmed R6's responsible party did not receive the SNFABN. During an interview on 8/6/25 at 2:24 p.m., the administrator (ADMIN) stated it is the expectation the SNFABN is provided to the beneficiary/responsible party when the NOMNC is provided if the beneficiary chooses to remain at the facility. A policy titled "Medicare Denial Procedure" reviewed 2/27/24, indicated "The Medicare Denial Notice will be delivered no later than 48 hours prior to discharge from services and far enough in advance to allow the Medicare beneficiary sufficient time to consider their options and make an informed choice regarding their right to appeal the decision that Medicare will not cover specific services." it continues "If the beneficiary will continue to stay in the care center, provide CMS-10123 Notice of Medicare Non-Coverage and CMS-10055 Fee For Services Skill Nursing Facility Advanced Beneficiary Notice of Non-Coverage which is the 'demand bill' portion used for the standard, manual appeal process."		F0582				
F0628 SS = C	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2);		F0628	How corrective action will be accomplished for those residents found to have been affected by the deficient practice.		09/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2025	
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 55992			
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F0628 SS = C		Continued from page 3 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.		F0628		Continued from page 3 The last three months of discharges, transfers and admissions was sent to the Ombudsman on 8/25/25. 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. We have a new Social Worker Designee starting on 9/4/25 who will be given the website and training on how to report this by the Administrator. The records will be sent quarterly, unless a 30-day discharge notice is given. Then the Ombudsman would be notified immediately. The Federal Requirements for Providing LTC Ombudsman Programs With Notice of Resident Transfer or Discharge were reviewed by the Administrator who will review them with the Social Worker Designee when she starts on 9/4/25. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator has it on her electronic and paper calendar as a reminder of when to send the information in. The Administrator will ensure the Social Worker Designee sends the information to the Ombudsman quarterly. The Social Work Designee will then report at a weekly meeting showing an ongoing record of all admissions/discharges/transfers to the Administrator. The Administrator will audit this weekly to ensure the records are being kept. The date that each deficiency will be corrected. 09/12/25	

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F0628 SS = C	Continued from page 4 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;		F0628				

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F0628 SS = C	Continued from page 5 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan,		F0628				

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F0628 SS = C	Continued from page 6 under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharges. During the survey documentation review and preparation process, the designated ombudsman was notified of the upcoming facility survey. Per electronic communication on 8/1/2025 at 10:38 a.m., ombudsman stated she had not received any notifications from the facility about transfers and discharges. During interview on 8/7/25 at 8:57 a.m., social worker		F0628				

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F0628 SS = C	Continued from page 7 (SW) stated she does keep track of admissions, discharges, and transfer. SW stated she was unaware she needed to send the admissions, discharges, and transfer notifications to the ombudsman. SW confirmed she had not sent the admissions, discharges, and transfer to the ombudsman. During interview on 8/7/25 at 9:53 a.m., administrator stated the SW is responsible for keeping a log of the facility admissions, discharges, and transfers. Administrator stated she is unaware if the SW had submitted the admissions, discharges, and transfer to the designated ombudsman. Administrator confirmed she had not sent the facility admissions, discharges, and transfer to the designated ombudsman. A policy was requested but was not received.	F0628		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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 food stored in the refrigerators were labeled and dated appropriately. This deficient practice had the potential to affect 35	F0812	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The food that was unlabeled was thrown out by the Dietary Manager within an hour of the discovery. The Dietary Manager went through all the food containers to ensure correct labeling. 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. The Dietary Manager reviewed the policy on food labeling with the dietary staff. The Dietary Manager will audit the coolers in the kitchen on a daily basis to ensure the containers are labeled. When the DM is not working, that day, the head cook will audit the coolers for dating of containers. A log will be signed off each day by the head cook and/or Dietary Manager of the audit on the containers. Training of this process will happen by 9/19/25. Training will be included in orientation of all new employees. Training will also be provided by 09/19/25, to the Nursing/NAR staff who sometimes handle secondary container dating needs. The Dietary Manager will audit the secondary facility refrigerators meant for resident use on a weekly basis on Wednesdays, starting 09/10/25. When the DM is absent, the head cook will be responsible for these audits.	09/19/2025

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F0812 SS = F	Continued from page 8 residents who received food from the refrigerators. Findings include: During an initial kitchen tour on 8/5/25 at 10:15 a.m., the large walk-in refrigerator contained an undated plastic container 1/2 full of soup. The refrigerator in the kitchen prep area contained an undated 3/4 full plastic container of potato salad and an undated plastic container 1/4 full of diced ham cubes. Cook (C)-A was unaware how old the soup was. C-A was unavailable to confirm date of potato salad or ham cubes. During a subsequent tour and interview on 8/7/25 at 11:01 a.m., dietary manager (DM)-A, indicated the soup, ham cubes, and potato salad had been removed from the refrigerators. Initial tour findings were discussed with DM-A. DM-A confirmed the soup, potato salad, and ham cubes were discarded on 8/6/25. DM-A stated leftovers are good for 48 hours and packaged foods are good 1 week after opening. DM-A stated it is expected all prepared foods and opened packages are dated prior to storage. A policy titled "Perishable Food Management" dated 8/29/22 indicated it is facility policy "All perishable food will be appropriately managed to prevent bacteria from multiplying or forming toxins." It defined "Use-by-date" as "the last date recommended for the use of the product while at peak quality. The product should be discarded once it is one day past the 'Use-by' date." Further, "Label" is defined as: "required on all foods not in original packaging. Should include food item description and dates. Dates should include: use-by-date or discard date." The policy further indicated leftover foods will be clearly labeled before being refrigerated or frozen and refrigerated leftover food must be used within 3 days, discarded on the 4th day.			F0812	Continued from page 8 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Dietary Manager will bring the completed logs to the quarterly QAPI meeting for a period of 6 months; October, 2025 and January, 2026. If no further instances of not labeling occur, the QAPI committee will decide whether the logs need to be brought to the meeting. The logs will continue as best practice. The date that each deficiency will be corrected. 09/19/25		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/06/2025. 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			09/02/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 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 1-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 (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. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.		K0000				

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K0000	Continued from page 2		K0000				
K0346 SS = C	The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification.		K0346				
	The facility has a capacity of 40 beds and had a census of 34 at the time of the survey.						
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
	Fire Alarm System - Out of Service			How corrective action will be accomplished for those residents found to have been affected by the deficient practice.		09/12/2025	
	CFR(s): NFPA 101						
	Fire Alarm - Out of Service			Revision of our policies: 4-hour Fire Alarm System Out of Service and 10-hour Fire Sprinkler System Out of Service have been revised and made specific to Zumbrota Health Services per request.			
	Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			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.			
	9.6.1.6			The new policies will be reviewed by the AWAIR team and the Department Heads by 9-4-25. The importance of the fire alarm/sprinkler system emergency phone numbers and location of the emergency binders was discussed at the all-staff meetings held on August 26th and August 28th.			
	This STANDARD is NOT MET as evidenced by:			How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.			
	Based on available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding a widespread impact on the residents within the facility.			The policy has been updated specifically to apply to Zumbrota Health Services and final approval has been given by the corporate office. It will be reviewed by the AWAIR committee members now and annually in August, and brought to QAPI as two of the policies being reviewed at quarterly QAPI in October, 2025 and October, 2026.			
	Findings include:			The date that each deficiency will be corrected.			
	On 08/06/2025 between 9:30 AM and 12.30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include in the same AHJ(s) notification listing as correctly identified in the Sprinkler System out-of-service policy.						
An interview with the Maintenance Director verified this deficient finding at the time of discovery.							

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K0346 SS = C	Sprinkler System - Maintenance and Testing 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1 , 5.2.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/06/2025 at 11:00 AM, it was revealed by observation that in Kitchen / Dishwashing area that sprinkler head(s) exhibited signs of debris loading / oxidation. 2. On 08/06/2025 at 11:05 AM, it was revealed by observation that in Dry Goods Storage area that sprinkler head(s) exhibited signs of debris loading /			K0346	Continued from page 3 09/12/25		09/12/2025
K0353 SS = F				K0353	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The sprinkler heads in question have been cleaned by the maintenance director to his ability. They still need professional attention. This has been scheduled for a day within the next week per Viking sprinkler company, so by September 10th, 2025. 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. Sprinkler heads are inspected annually by Viking Sprinkler. The maintenance director will inspect the heads at a quarterly point between the professional appt to ensure there is no build-up. Last inspection was in June 5th, 2025 by Viking sprinkler company. The water supply is from City of Zumbrota. Next inspection by internal maintenance director will be by end of September, 2025 and quarterly thereafter. Any sprinkler heads that can't be cleaned internally, will be cleaned by a professional sprinkler head company upon finding debris or build up. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Annual inspections by a professional sprinkler company will take place. At the quarterly point between the annual inspections, the on-site Maintenance Director will conduct and document an inspection. The quarterly inspections as well as the annual professional inspection will be reviewed at the closest in date, monthly AWAIR meeting. The AWAIR meeting minutes are reviewed at Quarterly QAPI. If there is build-up, Viking Sprinkler will be called to clean or replace. There will be no end date. This is best practice. The date that each deficiency will be corrected. 09/12/25		

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K0353 SS = F	Continued from page 4 oxidation.		K0353				
K0541 SS = D	An interview with the Maintenance Director verified these deficient findings at the time of discovery. Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/06/2025 at 11:10 AM, it was revealed by observation in the Laundry Chute Room that the chute		K0541	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The laundry chute door was adjusted by the on-site maintenance director and is working for now; however, the unit does need to be replaced. A replacement is being ordered by 9/5/25 and will be installed upon arrival. 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. The maintenance director will add the laundry chute door to his inspections every six months starting in February, 2026. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The inspection results will be brought to the closest in date, monthly AWAIR meeting for review. The date that each deficiency will be corrected. 09/04/25		09/04/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 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	
K0541 SS = D	Continued from page 5 intake door, upon testing, did not properly close and seal the vertical shaft opening.		K0541				
K0761 SS = F	An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery. 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/06/2025 at 11:30 AM, it was revealed by observation that the Basement Main Fire Door assembly upon test did not self-close and seal the opening. An interview with Maintenance Director verified this deficient finding at the time of discovery.		K0761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The door itself has been adjusted with more pressure to close against the air-pressure keeping it open. 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. When the fire alarm is activated, the HVAC system will shut down, causing the air pressure that does not allow this door to latch to be eliminated. The door does then shut according to requirements. This, along with the adjustment, has taken care of the issue. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. During Fire Alarm drills, the door in question will be checked by maintenance to ensure it does indeed close and latch. The date that each deficiency will be corrected. 09/12/25		09/12/2025	
K0920 SS = D	Electrical Equipment - Power Cords and Extens		K0920	How corrective action will be accomplished for those residents found to have been affected by the deficient		09/12/2025	

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NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET , ZUMBROTA, Minnesota, 55992	
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K0920 SS = D	Continued from page 6 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/06/2025 at 11:15 AM, it was revealed by observation, that at the Nurses Station a relocatable power tap was connected to work-station power strip. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920	Continued from page 6 practice. The daisy chain in question was immediately removed. The items needing an additional power source were relocated so no daisy chain or alternate power source is needed in that area. A sign was put up that says, 'no daisy chaining'. Employees were reminded what daisy chaining is; not to do it and report it when seeing it at the all-staff meetings held on August 26th and 28th. 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. At our monthly AWAIR meetings, areas of the building are assigned to be inspected. One of the areas for inspection to make sure isn't occurring is daisy chaining. The entire building is inspected for daisy chaining within a six-month period. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Inspections will be reviewed at monthly AWAIR meetings. Any issues that come up are put into the work order system by the Administrator and promptly taken care of. The date that each deficiency will be corrected. 09/12/25	
K0923 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	K0923	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The oxygen rooms have been organized into full and empty cylinder racks. Each room contains less than 300lbs of oxygen. The containers in the housekeeping	09/12/2025

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K0923 SS = F	Continued from page 7 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 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/06/2025 at 11:20 AM, it was revealed by observation that in the Med Gas Storage Room was found			K0923	Continued from page 7 area have been moved to secured storage. The cardboard containers have been replaced with plastic ones. 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. The HUC, who stocks the oxygen room, will do a weekly inspection to ensure empty cylinders are in their rack and full cylinders are in another designated rack. Signs have been placed on the doors indicating they are to remain closed and secured. The staff were reminded of the policy and contents during the all-staff meetings held August 26th and August 28th. The weekly inspections will start on 9/3/25. Oxygen training has been added to employee onboarding education. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Any irregularities not agreeing with policy will be brought to the attention of the Administrator and/or Maintenance Director for urgent follow-up. The inspection reports will be reviewed at monthly QAPI meetings. Quarterly QAPI in January, 2026 will decide if these weekly inspections should continue. The date that each deficiency will be corrected. 09/12/25		

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K0923 SS = F	Continued from page 8 unsecured – leaving the cylinders exposed to tamper and unauthorized access. 2. On 08/06/2025 at 11:20 AM, it was revealed by observation that in the Basement Housekeeping Office, there was unsecured storage of Med Gas cylinders and exposure to combustible materials that were locate within 5 feet of the cylinders. At time of discovery cylinders were fully exposed to tamper and unauthorized access. 3. On 08/06/2025 at 11:25 AM, it was revealed by observation that in the West Corridor of the facility adjacent to the Bathing Room, there was unsecured storage of Med Gas cylinders in the open corridor. At time of discovery cylinders were fully exposed to tamper and unauthorized access. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0923				
K0926 SS = C Bldg. 01	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding widespread impact on the residents within the facility. Findings include: On 08/06/2025 between 9:30 AM and 12.30 PM, it was revealed by a review of available documentation that documentation presented for review did not confirm that		K0926	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Medical gas training was completed at the All-Staff meetings held on August 26 and August 28, 2025. 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. Medical gases training has been added to the orientation program for all new hires and will be reviewed annually at all staff meetings. Next review would take place on or near August of 2026. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The HR director will keep a list of new hires that have completed the training and bring this to monthly QAPI for a period of three months. At the Quarterly QAPI in January, 26, it will be decided by the QAPI team if the presenting of the new hires being trained is needed to be reviewed by the QAPI team moving forward. Medical gas training will continue as regulated.		09/12/2025	

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K0926 SS = C Bldg. 01	Continued from page 9 staff are receiving initial medical gas training and/or refresher training on the risks associated with the handling of medical gases (O2). An interview with Administrator verified this deficient finding at the time of discovery.			K0926	Continued from page 9 The date that each deficiency will be corrected. 09/12/25		

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K0000	INITIAL COMMENTS		K0000			10/15/2025	
K0353 SS = F	Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey. Sprinkler System - Maintenance and Testing 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 STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.		K0353	Tag K0353 – Sprinkler heads in kitchen had debris and oxidation How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The sprinkler heads in question have been cleaned by the maintenance director to his ability. They still need professional attention. This has been scheduled for a day within the next week per sprinkler company, so by September 10th, 2025. The sprinkler contractor cancelled and didn't end up coming until September 24th. Pictures of cleaned heads were sent to the state Fire Marshal. 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. Sprinkler heads are inspected annually by a professional company. The maintenance director will inspect the heads at a quarterly point between the professional appt to ensure there is no build-up. Last inspection was in July, 2025 by the sprinkler company. Next inspection by internal maintenance director will be by end of October, 2025 and quarterly thereafter. Any sprinkler heads that can't be cleaned internally, will be cleaned by a professional sprinkler head company upon finding debris or build up. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Annual inspections by a professional sprinkler company will take place. At the quarterly point between the annual inspections, the on-site Maintenance Director		09/25/2025	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0353 SS = F				K0353	Continued from page 1 will conduct and document an inspection.		
K0541 SS = D Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.			K0541	Tag K0541 – Laundry chute door didn’t close properly How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The laundry chute door was adjusted by the on-site maintenance director and is working for now; however, the unit does need to be replaced. A replacement is being ordered by 9/5/25 and will be installed upon arrival. On September 18th, the laundry chute door was replaced as required during the FM's revisit. 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. The maintenance director will add the laundry chute door to his inspections every six months starting in February, 2026. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The inspection results will be brought to the closest in date, monthly AWAIR meeting for review. The date that each deficiency will be corrected. 09/04/25 revised to 09/18/25		09/18/2025



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 25, 2025

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, Mn 55992

RE: CCN: 245376

Cycle Start Date: August 7, 2025

Dear Administrator:

On September 26, 2025, we notified you a remedy was imposed. On November 10, 2025 the Minnesota Department Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 10, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 7, 2025 to be discontinued as of November 10, 2025. (42 CFR 488.417 (b))

In our letter of September 26, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 7, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File