DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 28, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: January 26, 2022

Dear Administrator:

On February 24, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
February 3, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: January 26, 2022

Dear Administrator:

On January 26, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 April 26, 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 July 26, 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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 01/26/2022

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
F 000	INITIAL COMMENTS On 1/26/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be UNSUBSTANTIATED : H5376028C (MN00080331) H5376029C (MN00080400) and H5376030C (MN00080402). However, a citation at F610 was issued. 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, the facility must acknowledge receipt of the electronic documents.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		2/18/22

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

Electronically Signed | 02/11/2022

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F 610	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were thoroughly investigated for 3 of 3 residents reviewed following an allegation of abuse. Findings include: R1's medical record was reviewed. R1's face sheet noted R1 had a diagnosis of pain to her left lower leg, parkinsonism, chronic kidney disease and disorientation. R1's care plan dated 9/16/20, noted R1 required assist of 1 person and mechanical EZ stand lift for transfers due to impaired mobility from cognitive and physical impairments. R1's significant change Minimum Data Set (MDS) dated 10/27/21, noted R1 to have moderately impaired cognition and required the extensive assistance of 1 person for transfers, dressing and locomotion on and off the unit. A report filed with the State Agency (SA) dated 1/19/22, noted a Nursing Assistant (NA)-A while in orientation and being trained in by NA-B, was witnessed speaking inappropriately to residents, was rough when assisting a resident to turn (R2), and was positioning a mechanical lift machine too high for 2 residents (R1, R3) causing those residents to have pain. The facility's internal investigation noted that on 1/19/22, R1 was in the EZ stand machine when NA-A elevated the mechanical lift high enough to	F 610	Zumbrota Health Services will follow the SNF Maltreatment Investigation and Reporting Policy for all accident/incident reports and allegations. They will be initially assessed by the person in charge at the time the incident takes place. An initial investigation will be conducted immediately to determine what happened. This may include resident and staff interviews, observations, and medical record reviews. Immediately following an accident/incident or allegation the nurse will perform pain, skin, and other relevant assessments on the affected residents and document the findings. All persons in charge and licensed nurses were re-educated on the policy of conducting an initial investigation immediately and completing and documenting required assessments on residents immediately following an incident. DON or designee will do random audits of accident/incident or allegations to ensure pain, skin, and other relevant assessments with documentation has been completed immediately following the incident. This will occur 2x a week for 4 weeks and then 1x a week for 4 weeks and then 2 audits a month to ensure continued compliance. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 610	Continued From page 2	F 610		

require R1 to be on her tip toes. R1 was saying the machine was too high and saying "ouch". NA-A replied to R1 that she had to stand up straight so NA-B could clean her up. NA-B instructed NA-A on proper height for R1, completed cares and assisted R1 to her reclining chair.

R2's medical record was reviewed. R2's face sheet noted R2 had diagnoses that included aphasia (loss of the ability to understand or express speech) following a stroke and hemiplegia affecting his dominant side.

R2's care plan dated 4/5/19 noted he had hemiplegia (paralysis) to his right side and 4/19/19 required cues to reach for grab bars in order to roll side to side in bed.

R2's significant change MDS dated 12/21/21, noted R2 to have severely impaired cognition and required the extensive assistance of 2 staff for bed mobility, transferring, and dressing.

The facility's internal investigation noted that on 1/19/22, NA-A and NA-B were assisting R2 to reposition him when NA-A stated "wow, he really doesn't help" and "that's not right, he should be helping". NA-B instructed NA-A that sometimes R2 gets stiff and requires more help. NA-A was witnessed "aggressively" turning / rolling R2. NA-A and NA-B used a mechanical lift and assisted R2 to his wheelchair.

R3's medical record was reviewed. R3's face sheet noted R3 had osteoarthritis, dementia and repeated falls.

R3's care plan dated 2/24/17 indicated R3

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F 610	Continued From page 3	F 610		

required the assistance of a mechanical lift to stand. On 5/18/18, it noted R3 was unable to ambulate due to degenerative joint disease along with back and hip pain.

R3's significant change MDS dated 10/27/21, noted R3 had moderately impaired cognition and required the extensive assistance of 2 for transfers and bed mobility.

The facility's internal investigation noted on of 1/19/22, NA-A and NA-B assisted R3 with a transfer using the mechanical lift. NA-A was witnessed elevating the lift to a higher level while R3 stated "ow, that hurts. You have to put it down". NA-A told R3 to be quiet and that it didn't hurt. NA-A and NA-B assisted R3 to the toilet and gave privacy.

The facility's investigation noted on the evening of 1/19/22, NA-B waited until she was not around NA-A to report the incidents to the charge nurse. The facility investigation noted several undated interviews with residents as well as undated interviews with two staff members that were working on the evening of 1/19/22. There were no resident assessments or observations in the facility investigative file.

When interviewed on 1/26/22, at 10:35 a.m. NA-B stated she was providing training for NA-A and witnessed the incidents. NA-B stated they started to provide cares on 1/19/22, around 4:50 p.m. and it was at approximately 5:30 p.m. that she went to a co-worker to have Registered Nurse (RN)-A make an excuse to pull her aside as she was fearful of NA-A. NA-B stated she explained what she witnessed to the nurse and was told the administrator would be notified. The administrator

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F 610	Continued From page 4	F 610		

spoke with NA-B and when she was finished, NA-B went to the dining room to assist residents for supper.

When interviewed on 1/26/22, at 10:45 a.m. RN-A stated that on 1/19/22, around 6:00 p.m. she was approached by NA-B. RN-A stated NA-B told her about the incidents with R1 and R3 as well as another resident who was later found to not have been involved. RN-A stated the administrator was notified and told her that NA-A would be suspended pending an investigation. RN-A stated it was the end of supper time and was shift change, she went and chatted with and asked about pain with R1. RN-A stated there was initial confusion of which residents were affected and she checked in with another resident that was mentioned by NA-B who was later found to not have been involved. RN-A stated after talking with residents, the oncoming nurse took over. RN-A stated she did not do a formal pain assessment; she did not do a skin assessment and did not document the conversations with the residents prior to leaving. RN-A stated she also did not enter a "late entry" form of documentation regarding the conversations with residents and denial of pain. RN-A stated a formal skin assessment would be expected following an incident such as this and would "dig deeper" if a resident did complain of pain following this kind of incident.

When interviewed on 1/26/22, at 11:51 a.m. the Assistant Director of Nursing (ADON) stated she expected that immediate action was taken to protect the residents by removing NA-A from the floor. The ADON stated the next action should be for a nurse to assess the residents involved for pain or injury. The ADON stated she expected a

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F 610	Continued From page 5	F 610		

nurse to assess the residents and document their findings, the ADON confirmed there was no documentation that R1, R2 or R3 were assessed by a nurse following the allegations. The ADON further stated she would expect a skin assessment, a pain assessment and for a nurse to go further for residents that have impaired cognition by checking vital signs for changes in their blood pressure that might indicate pain as well as range of motion to the residents' extremities.

When interviewed on 1/26/22, at 12:10 p.m. RN-B stated she was the oncoming nurse at 6:00 p.m. on 1/19/22. RN-B further stated she was told about the incidents however was not told about which residents were involved. RN-B stated she did not do follow up assessments on any residents that evening for pain or injuries as she did not know who was affected.

When interviewed on 1/26/22, at 12:24 p.m. the administrator stated she was working on the evening of 1/19/22 in the dietary department, she was notified by RN-A that NA-B was upset with the care that NA-A had provided to residents. The administrator stated at the time she was notified, NA-B was very upset and was unsure which residents were involved. The administrator stated NA-B told her how NA-A was elevating the mechanical lift too high for residents and how she was talking inappropriately to residents among other concerning issues. The administrator pulled NA-A aside and terminated her at that time. The administrator began a facility investigation that evening by an initial interview with NA-B, the administrator began to interview the residents the next day on 1/20/22. The administrator stated the Director of Nursing (DON) interviewed NA-B

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F 610	Continued From page 6 again on 1/21/22 and it was then that the names of the residents involved was known. The administrator stated she would expect a nurse to document pain and skin assessments following the incident and was aware there were no assessments documented in the EMR. A facility policy titled SNF Maltreatment Investigation and Reporting revised on 1/30/16, noted that all accident/incident reports and allegations will be initially assessed by the person in charge at the time the incident takes place. The policy further noted that an initial investigation must be conducted immediately to determine what happened. A facility policy titled Maltreatment Reporting Guidelines noted they should begin by conducting a facility investigation of the alleged maltreatment which may include resident and staff interviews, observations, and medical record review.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2022

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders
Event ID: V54611

Dear Administrator:

The above facility was surveyed on January 26, 2022 through January 26, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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, Health Program Representative Senior
Program Assurance | Licensing and Certification
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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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 1/26/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was foundin compliance with the MN State Licensure. The following complaint(s) were found to be UNSUBSTANTIATED: H5376028C	2 000		

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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) COMPLETE DATE
2 000	Continued From page 1 (MN00080331), H5376029C (MN00080400), and H5376030C (MN00080402). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		