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	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zumbrota Care Center	433 Mill Street Zumbrota, MN 55992

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review, the facility failed to report an elopement immediately to the administrator and to the State Agency within 2 hours for 1 of 1 resident (R1) who had eloped from the facility. Findings include: R1's face sheet dated 5/28/25, identified diagnoses of dementia (decline in mental ability and memory), delirium (a temporary state of mental confusion), and history of falling. R 1's Minimum Data Set (MDS) dated 2/6 /25, identified R1 needed supervision for transfers and had severe cognitive impairment. R1's elopement care plan focus dated 2/6/25, identified R1 was at risk for elopement related to history of attempts to leave the facility unattended. Interventions of wandergard on left wrist, encourage to attend activities during highest wandering times (late afternoon/evening), and distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1's progress note dated 5/8/25 at 7:45p.m., identified R1 had been observed wandering outside of the facility, R1 had a Wanderguard (a wander management system designed to help protect memory impaired residents from elopement) on her left wrist and worked properly, was alert and had intermittent confusion. R1's incident report dated 5/8/25 at 7:45 p.m., identified at R1 was found wandering outside of the building and R1 was orientated to person and time only. No predisposing environmental factors. Predisposing psychological factors included confusion and impaired memory. Door alarm/wandergard did not activate when R1 exited the building. Review of a report made to the state agency (SA) on 5/9/25 at 11:40 a.m., that R1 was found outside of the facility on the sidewalk in front of the building. R1 was brought back into the facility and reported that the Wanderguard alarm did not go off when R1 left the building, however the alarm did sound when R1 waw brought back in the building. The nurse did not report the elopement to the on-call nurse, administrator, or director of nursing to communicate R1's elopement. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 12:56 p.m., director of nursing (DON) stated that when R1 eloped from the facility it should have been reported to the administrator and the state agency immediately, but no later than two hours, but was not reported until the following day due to not being reported immediately after R1's elopement. Review of the facility's maltreatment reporting guidelines policy dated 11/26/24, identified any alleged maltreatment involving abuse neglect or financial exploitation injuries of unknown source or misappropriation a vulnerable adult property must be reported by the supervising employee of the building to the administrator of the care center immediately and to the state agency, but no later than two hours. Review of the facility's Elopement policy dated 8/1/22, identified when the resident who eloped is located: a. Complete a medical evaluation to identify potential injuries. b. Notify family and persons previously contacted. c. Notify the physician. d. Investigate to determine how the elopement occurred to correct any underlying contributing factors. e. Complete an Incident Report and document incident in the medical record. f. Report the 'elopement' incident to the state agency (MDH) as 'potential Neglect'.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect wander/elopement alarm use for 1 of 2 residents (R1) reviewed for MDS accuracy. Findings include: R1's quarterly MDS assessment dated [DATE], included section P0200: Alarms with alarm type wander/elopement alarm. The wander/elopement alarm was coded 0 indicating it was not used during the look-back period. R1's Elopement Risk assessment dated [DATE], indicated R1 had a Wanderguard placed on her right wrist. The analysis section noted for the assessment reference date (ARD) of 1/31/25 through 2/6/25, information was collected per review of documentation, observation, and interviews with direct care staff and resident. The analysis further noted, is at risk to wander or elope from facility. Wanderguard in place right wrist. Placement and proper function checked daily. R1's elopement care plan dated 8/28/24, identified she was an elopement risk. Intervention dated 8/28/24, noted R1 had a Wanderguard on her left wrist. On 5/19/25 at 4:01 p.m., the facility's nurse manager, registered nurse (RN)-C, confirmed R1 was one of the residents with a Wanderguard device. At 4:16 p.m., RN-C tested R1's Wanderguard device which was observed to be in place on her left wrist. During an interview on 5/23/25 at 2:05 p.m., the MDS Coordinator (MDS-C) stated R1's quarterly MDS dated [DATE] should have identified R1 had a Wanderguard in place and was not accurate. MDS-C noted she must have missed adding this to the MDS and she would be doing a modification to R1's MDS to correct it. Facility MDS assessment policy requested but not received.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to maintain a functioning Wanderguard system and failed to comprehensively assess risk for elopement and appropriate interventions, resulting in elopement for 2 of 7 residents (R1, R2). R1's elopement occurred due to the failure of the Wanderguard system, which did not sound an alarm when R1 exited the building. R2's elopements occurred due to R2's risk of elopement was not accurately comprehensively assessed leading to insufficient supervision and lack of intervention, followed by a failure of the Wanderguard system. The facility's failures resulted in an immediate jeopardy (IJ). The immediate jeopardy began on 5/8/25, when R1 successfully eloped from the building without the alarm sounding and was found by staff outside, unharmed, approximately 15 minutes later, the facility failed to identify malfunctioning alarm system which resulted in subsequent elopements by R2. The administrator, Director of Nursing (DON), nurse manager, and social services director were notified of the immediate jeopardy on 5/20/25 at 3:50 p.m. The immediate jeopardy was removed on 5/23/25, but noncompliance remained at the lower scope and severity level of D, indicating no actual harm but the potential for more than minimal harm, which is not immediate jeopardy Findings include: R1 R1's facesheet dated 5/28/25, identified diagnoses of dementia, delirium, and history of falling. R 1's Minimum Data Set (MDS) assessment dated [DATE], identified R1 had severe cognitive impairment and required supervision or touches for transfers, used a wheelchair and/or walker for mobility with staff supervision or touching. R1's elopement care plan focus dated 2/6/25, identified R1 was at risk for elopement related to history of attempts to leave the facility unattended. Interventions of Wanderguard on left wrist, and distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. R1's progress note dated 5/8/25 at 7:45p.m., identified R1 was observed wandering outside of the building, Wanderguard on left wrist and worked properly, was alert and had intermittent confusion. R1's incident report dated 5/8/25 at 7:45 p.m., identified R1 was observed wandering outside of the building and was orientated to person and time only. No predisposing environmental factors. Predisposing psychological factors included confusion and impaired memory. Door alarm/Wanderguard did not activate when R1 exited the building. R1's elopement care plan was revised on 5/9/25 to include encourage R1 to attend activities during highest wandering times (late afternoon/evening). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/20/25 at 1:21 p.m., registered nurse (RN)-A stated on 5/8/25 R1 had been observed in the facility about fifteen minutes earlier when around 7:30 p.m., staff observed R1 wandering outside of the facility near the gazebo, and then immediately brought back into the facility. The facility doors did not alarm when R1 left the facility, however, did go off when R1 was brought back into the facility. RN-A believed that the alarm not sounding may have been because the Wanderguard tag was on her left wrist and the door did not catch the signal. RN-A stated R1's Wanderguard was changed to a new one because it was due to expire soon. RN-A stated staff tested the doors and R1's Wanderguard when R1 returned and they both were working properly, however did not notify maintenance that the door failed to alarm when R1 had exited the building. During an interview on 5/20/25 at 1:27 p.m., director of nursing (DON) stated R1 eloped on 5/8/25 and R1 left the building without the Wanderguard system door alarm going off. R1 should have had a repeat elopement assessment completed at that time and all nurses were able to complete the assessment. DON indicated staff did not notify maintenance the alarm had not sounded and stated when R1 eloped staff should have notified maintenance immediately. In addition, staff should have assessed all resident Wanderguard devices to ensure proper function, check all doors with Wanderguard sensors to ensure proper function, and provide education to all staff in the building at the time about testing the system. DON stated, None of that was done. DON's expectation was for all doors to be tested for proper functioning if a resident eloped. DON was not aware of the manufacturer's recommendations for testing and did not know how the doors were being tested. R2 R2's facesheet dated 5/28/25, identified R2 had diagnoses including urinary tract infection (can cause confusion in the elderly), Parkinson's disease (progressive neurological disorder that affects movement), altered mental status, unspecified convulsions (sudden involuntary muscle contractions and spasms), unspecified dementia (condition causing loss in ability to think, remember, learn, make decisions, and problem solve and symptoms including personality changes and emotional problems), abnormalities of gait and mobility, amnesia (memory loss), rapid eye movement (REM) sleep behavior disorder (a disorder where people act out their dreams during REM sleep), macular degeneration (progressive eye disease of damage to the retina causing loss of central vision), dystrophies involving the retinal pigment epithelium (eye disease involving deposits of pigment in the retina that can cause central vision loss), vitreous degeneration (degeneration of the vitreous fluid in the eye leading to floaters and vision changes), hypermetropia (far-sightedness causing blurry close-up vision), and presbyopia (decline in eyes' ability to focus on nearby objects). R2's Minimum Data Set (MDS) assessment dated [DATE], identified she admitted to the facility on [DATE]. R2 had moderate cognitive impairment, delusions and verbal behavioral symptoms directed toward others, and had no wandering behaviors. R2 required substantial staff assistance with toileting hygiene, mobility in bed, and transfers. R2 used a wheelchair and was dependent on staff for wheelchair mobility. R2 was not independent with any self-cares or mobility. R2's physician orders dated 4/30/25, included: - Observe for side effects of antipsychotic medication. Side effects listed included disorientation or confusion, increased agitation, and restlessness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Melatonin (supplement to treat sleep problems like insomnia) 5 milligram (mg) tablet, give 10 mg by mouth as needed (PRN) at bedtime for restlessness/insomnia. R2's progress note dated 4/30/25, identified cognitive impairment of some forgetfulness. R2's Elopement Risk assessment dated [DATE], identified R2 had no history of elopement attempts and was a new resident within the last 90 days. The cognition section identified cognitive deficit of short-term memory loss and a change in cognition in the last 90 days. A pre-populated list of conditions contributing to elopement risk identified R2 had the following: recent infection, dementia, hallucinations, and new medication in the past 30 days. No behaviors, verbalizations, or life experiences that could contribute to elopement were identified and a Wanderguard (wearable bracelets that trigger alarms when a resident approaches a door sensor by an exit or restricted area) was not placed. The analysis noted, not at risk for elopement at time of assessment. The assessment failed to identify R2's conditions contributing to elopement risk of: altered mental status, amnesia, REM sleep behavior disorder, adjustment to new environment, and visual deficits. The assessment failed to identify R2's needed level of supervision or identify how it was determined that she was not at risk for elopement based on the risk factors identified. R2's care plan for psychotropic medications dated 5/1/25, identified she used psychotropic medications. Interventions included monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The intervention failed to identify R2's specific behaviors which were to be monitored and recorded. R2's behavior progress note dated 5/2/25, indicated she was heard calling out for help and found crawling out of bed at 12:20 a.m. R2 stated she wanted to get into her wheelchair, was brought to the common area by staff, requested a sandwich then specifically a fish sandwich, and declined other offered snacks. R2 stayed in her wheelchair until she requested to go to bed at 1:30 a.m. R2's progress note dated 5/2/25, identified she complained of trouble sleeping and requested PRN melatonin. R2's progress note dated 5/3/25, identified she requested PRN Melatonin due to difficulty falling asleep at night. R2's progress note dated 5/4/25, indicated R2 complained of trouble sleeping and took PRN Melatonin. R2's progress note dated 5/5/25 at 2:55 a.m., indicated the facility received a phone call from the police stating R2 called 911. R2 reported to staff that she called because she wanted to talk to her grandson and he was a police officer. R2 was redirected and went back to sleep. R2's progress note dated 5/5/25, noted R2 had trouble following commands, disorganized thinking, moderate cognitive impairment including memory loss and moderate confusion, and sometimes understood others. Behaviors included resident is awake at night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's progress note dated 5/5/25, indicated R2 had signs of short-term memory loss, mild cognitive impairment, and chronic confusion demonstrated by refusal of cares, refusal of redirection, and delusions. Mood and behaviors identified intermittent sleep and wandering at night. R2 was educated on safety concerns of impulsivity, poor safety awareness, and confusion. R2's progress note dated 5/5/25 at 9:06 p.m., indicated R2 came walking out of her room at 9:00 p.m. using her wheelchair as a walker. R2 took Melatonin and was up at the nursing station until more tired. R2's progress note dated 5/5/25 at 11:41 p.m., indicated she came out of her room at 11:00 p.m., stated staff needed to call 911 right now, and called 911 herself but would not say why. R2 took papers from the nursing station and refused to return the facility's phone. An officer arrived and spoke with R2, stated she did not complain of anything and the officer was not sure why they had been called. R2 returned to her room at 11:45 p.m. and refused to get into bed. Although R2's progress notes identified R2 had both wandering at night and increased behaviors there was no indication R2 was re-assessed for elopement risk or needed level of supervision nor were appropriate interventions developed, and implemented to prevent or mitigate the risk of elopement. R2's progress note dated 5/6/25 at 12:37 a.m., indicated a new medication, Trazadone (an anti-depressant also used to treat insomnia), was ordered for administration at bedtime as needed for sleep. R2's progress note dated 5/6/25, identified R2 came wheeling out of her room at 12:05 a.m. and went down the north hall. R2 then wheeled down to the end of the hall and turned around, backed her wheelchair by another resident room, began waving to something or someone she was seeing, and then entered the other resident's room. R2 then left the other resident room, propelled down the north hall back to the common area, and began saying good morning to a stationary chair. She signaled come here with her finger while looking at no one and sat next to the chair having a conversation with it. She then wheeled around in the common area, attempted to go behind the nursing station, and asked why those kids were back there. She continued to wheel around into the dining area, came out, was offered and took a PRN Trazadone to help with her insomnia, and wheeled herself back into her room. Progress note dated 5/6/25 at 1:25 a.m., identified R2 has been awake and roaming since beginning of night shift. R2's physician orders dated 5/6/25, included: - Trazadone hydrochloride (HCl) 50 mg tablet, give 50 mg by mouth one time a day for insomnia, difficulty falling, and/or staying asleep. - Observe for side effects of anti-depressant medication. Side effects listed included trouble sleeping and other unusual changes in mood or behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Behavior assessment dated [DATE], identified she had verbal behavioral symptoms directed towards others with examples listed including delusions and calling 911 without explanation. The assessment identified her behaviors did not put her at significant risk for physical illness or injury but did interfere with her care and significantly disrupt the care environment. Root cause of behaviors was identified as being newly admitted and diagnoses of Parkinson's disease, dementia, and seizure history. The assessment identified R2 had not exhibited wandering behaviors, despite progress notes indicating she repeatedly left her room at night and wandered around the facility. R2's progress note dated 5/10/25, identified R2 had some forgetfulness, slept intermittently, wandered at night, and wandering had decreased since starting a new sleep medication. R2's progress note dated 5/11/25, indicated she came walking out of her room with a walker at 9:00 p.m. and sat down in a chair. Staff explained she should not walk by herself and to request assistance when ready to return to her room. 15 minutes later R2 was found to have walked herself back to her room and stated she didn't need help and could walk just fine by herself. R2's behavior progress note dated 5/12/25 at 5:56 a.m., indicated R2 was not in her room on last rounds. R2 was found in a room at the end of a different hall, had her brief off, and was ducking down to hide when a nursing assistant opened the door. R2 was naked from the waist down and would not tell staff why she was in the room or what she was looking for. R2 was assisted back to her room and dressed. R2's progress note dated 5/14/25, indicated she wandered at night. R2's record between 5/6/25 and 5/15/25 identified despite R2 demonstrated several episodes of wandering, had confusion, forgetfulness, and had unpredictable ability to ambulate independently. There was no indication a comprehensive assessment was completed that would identify R2's risk for elopement and/or level of supervision nor evidence the care plan was revised. R2's incident report dated 5/16/25 at 8:00 p.m., identified registered nurse (RN)-B assisted R2 with a phone call and R2 then conversed with another resident at the nursing station. RN-B then left to take the other resident to their room and when RN-B came out of the room R2 wasn't at the nursing station. Staff began searching the facility immediately. RN-B went outside to search, and police had arrived and stated R2 had called 911. R2's spouse also arrived. R2 was found outside across the street without a wheelchair talking to her spouse using the neighbor's phone. Police and staff brought R2 back to the facility, she was assessed with no injuries noted and refused vital signs. R2's spouse sat with her until she fell asleep and a Wanderguard was placed on her left wrist. R2's physician orders dated 5/16/25, included: - Check Wanderguard functioning at bedtime. - Check placement of Wanderguard every shift for elopement risk. - Change Wanderguard one time a day every month on the 23rd day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's care plan for elopement dated 5/16/25, identified she was unable to leave the facility independently with history of elopement. Interventions included Wanderguard placed on left wrist, staff or family to supervise all outdoor activities, and family to sign R2 out in facility book before leaving. The care plan did not identify interventions that included needed level of supervision, identification and monitoring of behaviors/triggers/risk factors for elopement, or related management. R2's record lacked evidence she was comprehensively assessed for elopement risk prior to or on 5/16/25 despite her successful elopement from the facility that day. R2's record did not identify her needed level of supervision or appropriate interventions apart from placement of a Wanderguard. R2's record did not indicate how documented confusion, delusions, hallucinations, restlessness, agitation, visual and communication deficits, impulsivity, seeking behaviors and verbalizations, and desire to go home were comprehensively assessed, monitored, or mitigated to decrease related risk of elopement. R2's Elopement Risk assessment completed three days after R2 eloped dated 5/19/25, included R2 had made one previous attempt to elope on 5/16/25 when she ambulated unassisted to a neighbor's house across the street. The assessment identified she had a Wanderguard on her left wrist and she was a risk for elopement related to recent elopement. The assessment did not include or identify R2's documented cognitive deficit of intermittent confusion and conditions contributing to elopement risk of delusions, agitation, new medications within past 30 days, visual deficits, communication deficits, and REM sleep behavior disorder. The assessment did not identify R2's documented behaviors of impulsivity, agitation, restlessness, seeking behaviors, and verbalizations of looking for someone and seeking people. Further, the assessment failed to identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. During an interview on 5/19/25 at 1:30 p.m., R2 stated she had a Wanderguard on her wrist and R2's family member (FM)-A, noted it was placed the day before yesterday (5/17/25). FM-A stated this was placed because she had left the facility, and staff didn't know where she was for a few minutes. R2 stated she had been dreaming that she had to get away and ran out the door a block away barefooted even though she had been unable to walk on her own with therapy. FM-A stated this was confusing because most of the time she couldn't walk without her walker. R2 stated there was a man sitting outside at a house across the street and she used his phone to call 911, but did not remember why she called. FM-A indicated he was present when she returned to the facility, staff assessed her, and he stayed with her until she fell asleep. R2 stated they put the Wanderguard on her after that and she hadn't tried going outside since then (since 5/16/25). FM-A stated R2 had good days and bad days with memory due to her dementia and Parkinson's. Sometimes her moods were like a light switch and she would suddenly get quiet with a drained look and not say anything. R2's progress note dated 5/17/25 at 3:08 a.m., indicated R2 wheeled herself out of her room and around the common area. R2's behavior progress note dated 5/17/25 at 9:02 p.m., indicated she was seen by staff twice walking down the hall with her walker unassisted on the evening shift. R2's progress note dated 5/18/25, identified her thinking was disorganized. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/19/25 at 3:28 p.m., nursing assistant (NA)-E stated she knew if someone was an elopement risk because they would usually have a Wanderguard on and be on a list posted at the nursing station of residents who could not be left outside unattended. NA-E stated R2 was very confused all the time and always thinks she's going to go home. NA-E saw R2 yesterday (5/18/25) with all of her in clothes in her hands and the hangers taken off. R2 was confused since she admitted to the facility and was always trying to get out, wheeling herself around, didn't sleep, and couldn't sit still. R2 once thought it was time to go to bed at 2:00 p.m. R2 would wheel around and say she was going to go home mostly during the night, beginning around 6:00 p.m. when she would start to get anxious and confused. NA-E noted R2 was like fogged out and you could talk to her and she wouldn't respond at times. Staff knew Wanderguards worked when residents got close to the door, though there had been trouble recently where sometimes doors would alarm when a resident with a Wanderguard touched it and sometimes they would not. R2's progress note dated 5/19/25, indicated she had forgetfulness, signs of short-term memory loss, and disorganized thinking. R2's progress note dated 5/19/25, identified it was follow-up on the elopement note. A Wanderguard had been placed on her left wrist with orders to monitor placement and functioning and replace routinely, which was also added to her care plan. Diagnoses that could have contributed were identified as altered mental status, Parkinson's disease, dementia, and amnesia. A new elopement assessment had been completed. During an interview on 5/19/25 at 3:12 p.m., NA-D was not aware if R2 was an elopement risk and did not know R2 had a Wanderguard. NA-D knew if a resident had a Wanderguard because it would be on the resident, reported to staff, and on the care plan. NA-D knew who was at risk of elopement because it was reported to staff and the facility had a Wanderguard system that would detect when an at-risk resident was close to a door so staff could intervene and redirect. During an interview on 5/19/25 at 3:47 p.m., licensed practical nurse (LPN)-A stated residents at risk of elopement had Wanderguards and this was care planned and on the treatment administration record (TAR). LPN-A stated R2 was absolutely an elopement risk and had eloped on 5/16/25. LPN-A noted R2 would walk by herself outside of her room without a walker or footwear, stroll around in her wheelchair, and get antsy. LPN-A noted R2 had more behaviors at night. R2's elopement progress note dated 5/20/25, indicated R2 was sitting calmly in her wheelchair by the nursing station after receiving her pills at 9:10 p.m. RN-A went to the kitchen to put a meal tray away at approximately 9:30 p.m. at which time R2 remained in her wheelchair in the common area watching the birds. At approximately 9:40 p.m., RN-A returned to the nursing station and R2's wheelchair was still there but R2 was gone. RN-A began searching for R2 and alerted all staff, the DON, 911, and family. At approximately 10:20 p.m. the facility received a call from the police stating R2 had been found seven or eight blocks away, had fallen, did not appear injured, and would be transported to the emergency department for follow up. R2's emergency department hospital After Visit Summary dated 5/21/25, indicated she was discharged from the hospital and back to the facility. Imaging, labs, and tests looked good. Referrals were placed for memory care and in the meantime, it was okay for R2 to return to the facility. There were no new orders and no noted injuries. (continued on next page)

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Zumbrota Care Center	433 Mill Street Zumbrota, MN 55992

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Nursing Home Incident Report #360607 dated 5/20/25, was submitted to the state agency (SA) and identified R2 had eloped that evening. The incident description included Resident was discovered to not be in room, and subsequent search did not immediately show that she was in facility. Staff say they heard no alarms from the doors, which were armed at the time. During an interview on 5/23/25 at 10:30 a.m., RN-A stated she was working on 5/20/25 when R2 eloped. RN-A noted R2 was sitting and watching the birds when RN-A left the nursing station to go to the kitchen. RN-A stated upon her return approximately 10 minutes later, R2's wheelchair was still there but R2 was gone. RN-A stated the Wanderguard door alarms had not gone off, she was not aware R2 was missing until she returned and saw R2 missing. RN-A called 911, staff began to search, and police called the facility informing RN-A that R2 was found seven to eight blocks away, had stated she fell down, and would be transported to the emergency department. R2's Elopement Risk assessment dated [DATE], included R2 had made previous successful elopement attempts with frequency of one time event and note that R2 eloped five days ago and did elope again that evening, leaving the facility and ambulating seven or eight blocks away without walker or wheelchair. The assessment noted R2 had a Wanderguard on her left wrist due to elopement. The analysis section noted the circumstances of the elopement documented in progress note dated 5/20/25 and noted No pain or discomfort reported before the elopement. wander guard was [on, sic] her left wrist and works properly. The assessment failed to comprehensively or accurately identify all of R2's cognitive deficits, conditions and diagnoses contributing to elopement risk, and behaviors and verbalizations. Further, the assessment failed to identify R2's needed level of supervision or interventions to mitigate identified risk of elopement apart from placement of a Wanderguard. R2's elopement care plan was revised with new interventions on 5/20/25 that included: check placement of Wanderguard every shift, check function of Wanderguard daily, check expiration date of device; notify team (nursing, activities, housekeeping, dietary, social services) if I am observed to be wandering, purposeful wandering, or stating things such as I'm leaving, I need to find **, I am calling 911. R2's cognition care plan dated 5/20/25, identified R2 had impaired cognitive function/dementia or impaired thought processes. Interventions directed staff to cue, reorient, and supervise as needed (was not defined) and monitor/document/report as needed any changes in cognitive function. Additional intervention dated 5/20/25, for focus of psychotropic medication directed staff to identify target behaviors for monitoring/recording including wandering. R2's elopement care plan failed to identify her needed level of supervision or interventions to mitigate the identified risk of elopement apart from presence of a Wanderguard. The care plan identified the need to notify various individuals if wandering behaviors or verbalizations were noted, but did not identify how to manage/respond to these behaviors or mitigate the associated risk of elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/20/25, the facility's nurse manager, RN-C, stated residents were assessed for elopement risk on admission, with significant changes, annually, and as needed. A resident would be re-assessed if there was new or increased wandering, exit-seeking, or talk about leaving and should be done as soon as staff were aware of the behavior. Nurse managers completed the elopement risk assessments, but any nurse could do it. The assessment would be filled out and the nurse would make a decision about whether or not a person should have a Wanderguard on. RN-C stated she utilized the elopement risk assessment to determine if a resident needed a Wanderguard. There was no threshold on the assessment for when to place a Wanderguard or when someone was identified as an elopement risk, it was not an objective scale. RN-C stated she completed R2's initial elopement assessment dated [DATE]. RN-C stated the assessment should have identified R2's communication deficit, adjustment to a new environment, altered mental status, amnesia, and REM sleep behavior disorder because they contribute to elopement risk. If she had identified the aforementioned items on assessment, she would have identified her [R2] as an elopement risk and would have care planned this, though may not have applied a Wanderguard at that time. RN-C stated she had viewed the assessment as does she need a Wanderguard . not so much risk and would be looking at it differently in the future. RN-C confirmed the assessment was not accurate. She reviewed R2's progress notes, stated R2 was completely disoriented at night and exit-seeking, and R2 should have been re-assessed for elopement risk on 5/5/25 when she called 911 looking for her grandson because this was verbalizing looking for/seeking someone. RN-C noted ongoing progress notes prior to 5/16/25 identifying wandering behaviors and R2 should have been reassessed when she started having behaviors. RN-C stated a Wanderguard should have been applied when R2 started wandering at night and this would have helped to mitigate her risk of elopement. RN-C stated it wasn't applied until after her elopement on 5/16/25 and confirmed no other interventions to mitigate risk of elopement were implemented. RN-C confirmed she did not see any comprehensive assessment to determine R2's needed level of supervision and we did not assess for her level of supervision or put any interventions in place. RN-C noted if the Wanderguard system was not functioning properly, then the facility had no interventions in place. She was unaware the Wanderguard system was not functioning properly and did not think R2's current level of supervision was adequate, especially at night. Further noted R2 eloped on 5/16/25 and should have been re-assessed for elopement risk that evening once she was back in the building, but confirmed an assessment was not completed until 5/19/25. During observation and interview on 5/20/25 at 8:44 a.m., Environmental Services Director (ESD) stated the five doors with Wanderguard systems were tested daily using an extra Wanderguard device signaling bracelet to ensure the system was working properly. The ESD noted the tests were recorded in a logbook but, upon review of the logs, stated they had not been completed consistently. The ESD and surveyor proceeded to test the five doors with an extra Wanderguard bracelet and found the following: four of the five doors did not alarm when the Wanderguard bracelet was in proximity of the door alarm, and one of the five doors did not alarm when passed through with the bracelet with the doors already opened by the automatic door button. During a follow up interview at 3:15 p.m., ESD stated he was not aware of any current issues with the Wanderguard system prior to this testing including both alarms not sounding due to Wanderguard bracelet proximity and the ability to exit a door without an alarm sounding. The ESD was not aware of how long these issues had been going on, no concerns had been reported by staff completing routine daily door testing. In a subsequent interview on 5/23/25 at 12:14 p.m., ESD stated the Wanderguard system had been inspected by a technician on 5/21/25 and a dead spot of about one foot on two of the five doors was identified. ESD stated if a resident with a Wanderguard bracelet exited through these doors the alarm would not sound because of the area of not reading the bracelet. New antennas and control box were installed to remove the area where the bracelets were not detected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/20/25 at 10:35 a.m., the administrator stated staff relied on the Wanderguard system to know if a resident at risk of elopement had left the building. Staff would know because of the beeping at the doors from the Wanderguard alarms. Administrator acknowledged the system had failed. She noted the doors were tested daily by maintenance and she would expect the system to be tested in accordance with manufacturer recommendations. She would expect the Wanderguard system to be functional 24 hours per day seven days per week and a resident with a Wanderguard should not be able to get through the door without the alarm sounding. She noted the doors should be set up to alarm when a resident's Wanderguard device was in proximity, not only upon the door being opened. Administrator was not aware that it was currently possible, as established by the surveyor and maintenance testing the doors, to get a Wanderguard bracelet through a door without it alarming or to approach a door without it alarming. This was horrifying and possibly how R1 was able to elope from the facility. If the door did not alarm, staff wouldn't be aware that a resident had eloped until they were noted to be missing. We obviously need to fix our system. In the absence of a functioning system, staff would check on residents who were elopement risks but that was probably not realistic because the facility was a big place. Staff would not be able to adequately supervise residents with Wand[TRUNCATED]

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and document review, the facility failed to post accurate data reflecting the total number and actual hours worked per shift by nursing staff directly responsible for resident care on a daily basis. This had the potential to affect all 34 residents residing in the facility and their visitors who may wish to review the information. Findings include: The facility's nurse staff posting form with date revised 4/17/25, included two pages for each calendar day. The first, titled [Facility] Nursing Schedule, included the following information: Nursing staff roles/titles (nurse, charge nurse, trained medication aide (TMA), nursing assistant (NA), and nurse on-call); names of staff filling the specific role for a given shift; scheduled hours of the shift with start time and end time. The second, titled Report of Nursing Staff Directly Responsible for Resident Care, included the date and daily census as well as a list identifying position (registered nurse (RN), licensed practical nurse (LPN), TMA, and NA), shift worked, hours (number of staff who worked the specified shift in the specified role), and total hours covered. The facility's Nursing Schedule dated 5/17/25, included an NA, NA-F, identified as working from 10:00 p.m. to 6:30 a.m. with letters AL written in and circled next to the name. There were no modifications made to the listed shift hours of 10:00 p.m. to 6:30 a.m. The Report of Nursing Staff Directly Responsible for Resident Care dated 5/17/25, included an entry for position of NA, shift worked from 10:00 p.m. to 6:30 a.m., hours times one, and total hours worked of eight. In an email dated 5/19/25 at 5:50 p.m., the administrator noted the facility's overnight staff covered the assisted living center in addition to the facility and did not believe those hours were being tracked. In a subsequent email at 6:02 p.m., the administrator indicated there was a tracking log and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it! signed by the director of nursing (DON). Additional hand-written note directed Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take. The log book sheets with entries from month of May 2025 included columns for room number, time of call, total time spent, what they needed, and any other information. The room number column was used by staff to document the date and other information column used by staff to sign their initials. AL Filling in Time Book entries corresponding with NA-F's shift from 5/17/25 at 10:00 p.m. through 5/18/25 at 6:30 a.m. included the following: - 5/17/25 at 10:00 p.m., 10 minutes total time spent for key handoff, with NA-F's initials. - 5/18/25 at 1:00 a.m., 20 minutes total time spent for rounds, with NA-F's initials. - 5/18/25 at 3:15 a.m., 20 minutes total time spent for rounds, with NA-F's initials. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	- 5/18/25 at 6:00 a.m., 10 minutes total time spent for key handoff, with NA-F's initials. The total documented time NA-F spent working at the assisted living and not in the nursing home during the shift from 10:00 p.m. to 6:30 a.m. was one hour. The facility's nurse staff posting dated 5/17/25, failed to reflect the time NA-F spent working at the assisted living and not the nursing home. Neither the actual hours worked (listed as 10:00 p.m. to 6:30 a.m.) nor the total hours worked (listed as eight) accurately reflected NA-F's time spent providing resident care in the facility. Based on documentation provided and reviewed above, accurate documentation would have included actual hours worked of 10:10 p.m. to 1:00 a.m., 1:20 a.m. to 3:15 a.m., 3:35 a.m. to 6:00 a.m., and 6:10 a.m. to 6:30 a.m. as well as total hours worked of seven. During an interview on 5/19/25 at 3:28 p.m., nursing assistant NA-E stated nursing staff were responsible for the residents at the connected assisted living at night and had to take care of the residents in both facilities simultaneously. NA-E indicated staff from the nursing home would go over to the assisted living facility to provide cares and assistance. During an interview on 5/23/25 at 11:45 a.m., the staffing coordinator (SC) stated the nurse staff postings for the facility did not reflect the hours staff worked in the assisted living and therefore were not accurate. The SC further stated the hours should be adjusted in real time such as if someone called off for their shift, but this was not completed until the next day when she came in to work. During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night. The administrator confirmed these staff assisted with providing cares at the assisted living during their shifts at the facility. During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began. In a subsequent interview on 5/23/25 at 11:54 a.m., the DON stated the posted nurse staffing hours included identification of certain staff assigned each day to cover helping in the assisted living (staff with AL written next to their names), however the postings did not reflect the specific time or amount of time that was spent working outside of the nursing home. Facility policy on staffing was requested but not received.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to be in compliance with the supplemental nursing service agency (SNSA) requirements when the facility obtained nursing services from Swenswen Staffing, LLC (an SNSA) which was not registered with the commissioner as required. This had the potential to affect all 34 residents of the facility who received services from the supplemental staff. Findings include: Review of the SNSA website on [DATE], did not identify [NAME] Staffing, LLC as being registered with the commissioner as required. Email communication sent on [DATE] at 3:09 p.m., the staffing coordinator (SC) verified that Swenswen Staffing had provided staff in the facility in the past month. Review of the staffing schedules from [DATE] through [DATE], verified that Swenswen Staffing, LLC provided supplemental nursing staffing to the facility on the following days: -[DATE] nursing assistant 6:00 p.m. to 6:30 a.m. -[DATE] trained medication aide 1:00 p.m. to 2:00 p.m. -[DATE] trained medication aide from 6:00 a.m. to 6:00 p.m. -[DATE] trained medication aide from 6:00 a.m. to 6:00 p.m. -[DATE] trained medication aide from 6:00 a.m. to 6:00 p.m. -[DATE] trained medication aide from 6:00 a.m. to 6:00 p.m. -[DATE] trained medication aide from 6:00 a.m. to 6:00 p.m. -[DATE] nursing assistant from 6:00 p.m. to 6:30 a.m. Review of the Minnesota Department of Health approved SNSA's current as of [DATE] did not include [NAME] Staffing, LLC. Review of an email dated [DATE] at 6:50 p.m., Swenswen Staffing, LLC forward a certificate for registration as a SNSA, however it had expired on [DATE]. During an interview on [DATE] at 4:09 p.m., the Administrator stated she was not aware that Swenswen Staffing, LLC was not registered as required and was not aware of the facility's responsibility to verify that the SNSA was registered prior to obtaining staff from the agency. A policy on supplemental staffing was requested but was not provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to review and update the facility assessment to identify the facility's staffing plan for number of staff needed to ensure sufficient qualified staff were available to meet residents' needs. Findings include: In an email dated 5/19/25 at 5:50 p.m., the administrator noted overnight staff at the facility also worked at the assisted living facility. She noted this was an oversight if that isn't listed in the facility assessment and she would work on getting it corrected as soon as possible. In a subsequent email at 6:02 p.m., the administrator indicated there was a tracking log and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it! signed by the director of nursing (DON). Additional hand-written note directed Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take. The log book sheet entries identified that overnight staff spent time working in the assisted living nearly every single day, multiple times per shift. The facility assessment dated [DATE], noted it was coordinated by the current administrator and last reviewed and approved at Quality Assessment and Assurance/Quality Assurance and Performance Improvement (QAA/QAPI) on 2/7/25. The assessment included a staffing plan with assessment date 4/8/25. The staffing plan identified staff positions and total number needed or average or range for each position with note to indicate any shared positions. The staffing plan identified licensed nurses providing direct care included two on day shifts, two on evening shifts, and one on overnight shifts for both weekdays and weekends. Nursing assistants (NA's) and trained medication aides (TMA's) included three to four NA's/TMA's on days shifts, three NA's/TMA's on evening shifts, and two NA's/TMA's on overnight shifts for both weekdays and weekends. The staffing plan did not identify any of the licensed nurse, NA, or TMA positions or shifts as being shared with the assisted living or reflect the needed number of staff or hours worked in the facility for each role adjusted for time spent working in the assisted living. The facility assessment failed to accurately identify the number of staff needed to meet resident needs and was not updated to identify that nursing staff were shared with the assisted living. During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night. The administrator confirmed these staff assisted with providing cares at the assisted living during their shifts at the facility. In a subsequent interview on 5/23/25 at 3:43 p.m., the administrator stated the facility assessment was completed prior to her employment at the facility which began two months ago. She believed it was last updated in 2024. This was not consistent with documentation in the facility assessment. In a subsequent interview on 5/27/25 at 4:59 p.m., the Administrator stated the facility assessment was not reflective of the actual hours worked in the nursing home because the staff hours worked in the assisted living had been counted towards the facility's identified staffing hours determined by the assessment. The administrator further noted the current facility assessment was therefore not correct. Facility assessment policy requested but not received.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review the facility failed to submit accurate and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter (Quarter 2) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 34 residents of the facility who received services from the supplemental staff. Findings include: CMS CASPER Report 1702S titled Staffing Summary Report for dates 1/1/25 through 3/31/25, was a Payroll Based Journal (PBJ) report and included a summary of staffing hours listed by job title. The reported identified the following total nursing staff hours for Quarter 2: - Certified nurse aide (nursing assistant, NA), 5,491.52 hours - Registered nurse (RN), 2,393,98 hours - Licensed practical/vocational nurse (LPN), 2,018.75 - RN director of nursing (DON), 488.00 - Medication aide/technician (trained medication aide, TMA), 131.00 In an email dated 5/19/25 at 5:50 p.m., the administrator noted the facility's overnight staff covered the assisted living center in addition to the facility. In a follow-up email at 6:02 p.m., the administrator indicated there was a tracking log and provided an hours log of nursing home staff covering at the assisted living (AL) titled AL Filling In Time Book. Facility document titled AL Filling in Time Book was a log book with dated entries from 3/9/25 through 5/19/25. The log directed staff: Please write down times for the following: counting meds, rounds, any call lights/calls you get, falls, potential emergencies. Any time you go over there please document it! signed by the director of nursing (DON). Additional hand-written note directed Please fill out when you get calls/go to the ALF [assisted living facility]. Thanks, [DON]. Please write down rounds too! & how long those take. The log book sheets with entries from month of May 2025 included columns for room number, time of call, total time spent, what they needed, and any other information. The room number column was used by staff to document the date and other information column used by staff to sign their initials. AL Filling in Time Book included entries from various staff members during Quarter 2 dated 3/9/25 through 3/31/25, documenting time spent working at the assisted living and not the facility. The total documented time spent by facility staff working at the assisted living from 3/9/25 through 3/31/25, was greater than 50 hours. Some entries were illegible or identified time was spent at the assisted living but did not identify the total amount of time spent. (continued on next page)

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	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zumbrota Care Center	433 Mill Street Zumbrota, MN 55992

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 5/20/25 at 4:55 p.m., the DON stated facility staff had been providing services at the assisted living since before she started working there in October of 2023. She was not sure exactly when this practice began. During an interview on 5/20/25 at 10:35 a.m., the administrator stated the facility was typically staffed with one nurse and two NA's at night and confirmed these staff members assisted with providing cares at the assisted living during their shifts at the facility. During an interview on 5/23/25 at 12:03 p.m., the director of human resources (DHR) stated he assisted with staff timecards (clock in/out time punches) and used the timecard data for the facility's PBJ reporting of staffing hours. However, the DHR stated he had not been subtracting the time staff spent in the assisted living to reflect the actual time spent working in the facility for the PBJ reporting. The DHR noted they would subtract the hours moving forward now that the facility realized they should have done this. The DHR stated he started working at the facility a few months ago and, since then, the PBJ hours submitted would have been incorrect. Facility PBJ policy requested but not received.