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	11/26/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 comprehensively assess each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls.Findings include: R2's Fall Risk Evaluation dated 6/12/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was ambulatory and continent. R2 had balance problem while standing and walking and required the use of assistive devices. R2 currently takes 3-4 high risk medications. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations, determine ability to transfer, and if fall occurs alert provider.R2's quarterly minimum data set (MDS) dated [DATE], identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. R2 had one fall with no injury and 1 fall with injury. R2's care plan revised 4/25/25, identified a focus that R2 was at risk for falls related to gait, balance and cognition problems. History of falls with major injury, fracture of left hip requiring surgical interventions. Interventions revised on 4/10/25, directed staff to use a stationary nonreclining chair, be sure call light was in reach, Dycem placed on chair surface, use of a Reacher to help with prevention of falls, low pile mat under stationary chair and sign placed in room to remind to use call light to ask for assist. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Intervention dated 8/23/24, directed staff to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn.Furthermore, an additional focus was revised 6/5/25, with activities of daily living (ADL) performance deficit related to disease process. Intervention dated 5/13/25, directed staff that R2 was assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet.R2's Fall incident report dated 9/5/25, identified at 2:30 p.m., another resident notified staff that R2 was on the floor. R2 was found face down on the floor next to his bed. R2's clothing was wet, and water was all over the floor. R2 sustained a skin tear to his right knee and knuckles on the right hand were red. R2 stated that he spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up when he fell. Immediate action taken: R2 was placed back in his wheelchair per his request and silent alarm engaged. Reinforced the need to use call light.R2's Post Fall evaluation note dated 9/5/25 at 3:30 p.m., identified contributing factors of R2's fall was water was spilled on the floor and was incontinent at the time of the fall.R2's Fall progress note dated 9/5/25 at 4:00 p.m., identified root cause of fall was R2 spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up. Intervention was a silent alarm was engaged, and writer reinforced the (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	importance of using his call light when he needed assistance.R2's Fall interdisciplinary team (IDT) note dated 9/5/25 at 4:12 p.m., identified a root cause analysis that R2 dropped his water cup on the floor and reached forward in his wheelchair thinking he could pick it up off the floor. Intervention was R2's grippy socks were on and did not engage his call light. Follow up: signs were up in room to call for assistance and was wearing his call light. Encourage R2 to be out of his room and out in public spaces around others.Review of R2's record identified R2 was incontinent at the time of the fall on 9/5/25, needed assist with toileting, did not identify the last time R2 was toileted, no toileting care plan in place and toileting was not addressed. Furthermore, interventions the facility identified was a silent alarm, encourage to be out of his room and out in public spaces that were not updated to R2's care plan.R2's Fall Risk Evaluation dated 9/10/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was chairbound and incontinent. R2 had gait/balance problem and required the use of assistive devices. R2 currently took 3-4 high risk medications within the last 7 days. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations and if resident was a fall risk initiate fall risk precaution. Clinical suggestion to utilize a toileting program was left blank.R2's fall care plan was revised on 9/16/25 to include anti-tip bars on wheelchair however there was no corresponding assessment that identified why this intervention was implemented. R2's Fall incident report dated 9/23/25 at 6:20 p.m., identified R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. R2 stated, I was trying to do it by myself. Call light was not engaged. R2 had cut his right thumb and index finger. R2 assisted by using Hoyer lift into his bed. Resident offered complaints of back pain 6 out of 10, PRN (as needed) tramadol (pain med) received. Right thumb and index finger cleaned, steri strip applied, cover with gauze, and rolled gauze. Vital signs within normal limits. Resident Description: Self-transfer. R2 stated he tried to go to the bathroom by himself. Immediate action taken was R2 was assisted into his bed, reeducated on call light use and grippy socks were in place.R2's Fall progress note dated 9/23/25, identified the aforementioned information in addition to, an aide called for assistance in R2's room. Upon arrival R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. Root cause was self-transfer.R2's Post Fall evaluation note dated 9/24/25, identified the fall on 9/23/25 with the aforementioned information. The note also included the contributing factors of this fall were R2 was incontinent at the time of the fall and diagnoses of Lewy bodies, dementia and Parkinson's does not allow R2 to make safe decisions. Root cause of fall was self-transfer. Intervention: R2 was reeducated on call light use and assisted into bed using a Hoyer lift. R2's Fall IDT note dated 9/24/25, identified R2 fell in his bathroom, Root cause analysis was R2 stated, I wanted to do it myself, and unable to make safe decisions due to his dementia, parkinsonism and Lewy Bodies. Interventions: physical therapy occupational therapy (PT/OT) will work with him to build strength and safe transfers, and we will have the physician review his meds to see if anything needs to be removed or added.R2's progress note dated 9/25/25 at 9:48 p.m., identified R2 continued to demonstrate poor safety awareness, in addition to current fall precautions a cushioned floor mat was placed beside the bed on R2's exit side. The bed is on the lower position and locked, call light within reach. R2 denied having pain or discomfort this evening.Review of R2's record identified although the fall record identified causal factors of self-transfer and R2 was incontinent at the time of the fall on 9/23/25, there was no indication a comprehensive assessment to determine individualized interventions was completed to negate R2's risk of falls related to self-transfers due to needing to use the bathroom. In addition, the care plan was not updated to reflect a low bed or floor mat.R2's Fall progress note dated 9/28/25, identified another resident alerted staff that R2 was on the floor in his room on his knees. R2 was trying to get back in his recliner and was visibly upset about the situation. Root cause was R2 wanted to sit in his recliner, intervention was to remind to use the call light, so he does not get hurt. No injury noted with fall. Intervention was frequent checks completed on R2 throughout the evening. R2's Fall incident report for 9/28/25 was not found in R2's medical record.R2's Fall IDT note dated 9/29/25, identified R2 had a fall in his room on 9/28/25 at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:15 p.m. Root cause analysis identified potential diagnoses that could have contributed to fall are recent fractured left femur, dementia, parkinsonism, Lewy body dementia, low back pain due to spinal stenosis/lumbar, chronic pain, orthostatic hypotension, history of falling, weakness, and major depressive disorder. Care plan was reviewed with current fall interventions in place, most recent was 6/10/25, anti-tip bars on wheelchair. Interventions pending lab results including urinalysis to guide any additional interventions. Potential interventions include bilateral lower extremity wraps to support blood pressure, obtain ortho blood pressures, place non-slip strips next to bed and in front of toilet, IDT review will convene following test results to determine specific intervention. In review of R2's record there is no indication an intervention was developed and implemented that mitigated the risk of falls based on the identified root cause of R2 independently transferring to his recliner. Furthermore, there was no indication the care plan was updated to include interventions of frequent checks, non-slip strips next to the bed and in front of the toilet. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner with his front wheeled walker within reach. R2 stated he needed help getting to the bathroom so he would not fall. R2 did not always make it to the bathroom in time and had accidents because staff did not always offer to help him to the bathroom. Staff had put a sign in his room to remind him to call for help but did not always remember to look at the sign to call for help. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's Kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 had diagnosis of Lewy bodies so he did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting which could lead to him falling. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated two of R2's last three falls identified he was incontinent at the time of the fall and toileting was not addressed and should have been. NM-A stated R2 did not currently have a toileting plan in place but should due to his incontinence and the need for assist with toileting and transfers. NM-A stated each fall should be thoroughly investigated to determine a root cause to ensure the appropriate fall prevention plan is updated to the care plan to direct staff to prevent future falls. NM-A stated R2's last fall was not thoroughly investigated, there was no incident report filled out and there was no post fall incident completed to determine a root cause analysis and there was no new intervention for fall prevention put in place. Facility policy, Fall Prevention and Management, reviewed 6/5/23, POLICY: The care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. PURPOSE: To provide guidance to care center staff on assessing, identifying, and managing care for those residents at risk for falls. PROCEDURE: The care center will assess each resident's risk for falls at move in, quarterly and with any significant change in condition and will identify interventions to help prevent falls and/or to prevent injuries from falls. D. Post Fall Assessment: If a fall occurs while the individual is residing in the care center (or off premises on a care center specific activity) staff will perform the incident fall tracking assessment. a. Nursing staff will complete a fall scene investigation, assess the resident, and call for any additional assistance or 911 as necessary. b. An immediate intervention will be put into place, according to the immediate determination of the potential root cause of the fall, to prevent further falls until the root cause analysis (RCA) of the incident is completed. c. Nursing staff will document the fall by completing an Incident Report in the electronic medical record. From the immediate assessment of the incident, a determination will be made if the incident involved any maltreatment and/or serious bodily injury. If so, administrative staff will be notified, and a report of the incident will be sent to the State agency. e. The interdisciplinary team (IDT) will evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that are developed will be documented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop an individualized toileting program to maintain or improve bowel/bladder continence for 1 of 3 residents (R2) reviewed for falls. Findings includeR2's quarterly minimum data set (MDS) dated [DATE], identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel.In review of R2's record there was no indication a comprehensive bowel and bladder assessment was completed. R2's care plan revised 6/5/25, identified a focus with activities of daily living (ADL) performance deficit related to disease process. Goal revised 8/5/25, identified to improve current level of function through the review date, will be back to baseline and assist with adl's. Intervention dated 5/13/25, assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet.An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Goal revised 8/8/25, identified R2 will remain free from skin breakdown due to incontinence and brief use through the review date. Intervention dated 8/23/24, identified to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn.R2's care plan did not include and individualized toileting schedule/program. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner and had his front wheeled walker within reach. R2 stated he needed help getting to the bathroom, so he doesn't fall. R2 did not always get to the bathroom in time and would have accidents because staff did not always offer to help him to the toilet. R2 stated staff put this a sign on his dresser to remind him to call for help so he doesn't fall, but he did not always remember to look at the sign to ask for help. R2 explained that it's difficult to remember to look for a sign and press the help button when you instinctively assume you can do things on your own.During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated R2 did not currently have a toileting plan in place but should have one due to his incontinence and the need for assist with toileting and transfers. NM-A was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. NM-A stated the facility did not really have a process in place for a personalized toileting plan and indicated they need to develop one.Facility policy titled, Urinary Incontinence Program, reviewed 4/16/15, identified POLICY: St. [NAME] Health Services of [NAME], Inc. (SFHS) provides care to those residents who are incontinent that will restore normal bladder and bowel function to the greatest extent possible, or at least prevent related incontinence complications. PURPOSE: Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. PROCEDURE: A. Each resident will be evaluated upon admission. The evaluation will include completion of a baseline review of the resident's elimination status. A comprehensive assessment, which will include a three (3) day bowel and bladder pattern assessment, will be completed within the initial assessment period. a. Based on the initial urinary incontinence or bowel incontinence history (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported by the resident and/or family member(s), the new resident will be assisted in using incontinence products provided by the care center. Measurements of the resident, pattern of reported incontinence, incontinence product protocols for product use, and resident choice will be considered in the choice of incontinence product(s). b. The 3-day bowel and bladder pattern assessment will be completed and documented in hourly increments. A component of the three (3) day bowel and bladder pattern assessment may include bladder ultrasound equipment use. c. The comprehensive bowel and bladder assessment will include a report of prior incontinence history, a physical examination, documentation of genitourinary tract anomalies, results of the three (3) day bowel and bladder pattern, a review of diagnoses and medications that may impact urinary or bowel status, food and fluid intake patterns, environmental concerns as well as the consideration of adaptive devices, review of potential or existing complications of incontinence, and the resident's level of need for assistance due to physical or cognitive impairments. This assessment will be used to determine an individualized bowel and bladder program for each resident. Bowel and Bladder Policy, revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence.2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents' condition.