

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Zumbrota Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents whose Medicare Part A services were ending, but who remained in the facility, received the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (Form CMS-10055) prior to the termination of services to advise them of potential costs and options. This affected 2 of 3 residents (R4 and R31) reviewed for Medicare Part A coverage termination. Findings include: R31's medical record indicated R31 admitted [DATE] on Medicare part A coverage and ended coverage on 5/11/26. On 5/12/26 R31 remained in the facility on private pay. R31's NOMNC signed 5/7/26 by R31 identified R31's Medicare coverage would end 5/11/26. R31's electronic medical record lacked evidence a SNFABN was provided to R31 or their representative to advise on potential cost of staying in the facility after Medicare Part A ends and to offer the choice of receiving the offered services, asking Medicare to be billed or declining the offered services. R4's medical record indicated R4 started Medicare part A coverage on 5/4/26 and ended coverage on 6/27/26. On 6/28/26 R4 remained in the facility on private pay. R4's Notice of Medicare Non-coverage (NOMNC) signed 6/24/26, identified R4's Medicare Coverage would end on 6/27/26. The form indicated verbal consent was received from R4's responsible party on 6/24/26 and signed by facility social services employee (SS)-A. R4's electronic medical record lacked evidence a SNFABN was provided to R4 or their representative to advise of potential cost of staying in the facility after Medicare Part A ends and to offer the choice of receiving the offered services, asking Medicare to be billed or declining the offered services. During an interview on 7/28/26 at 11:30 a.m., Social Service (SS)-A stated the facility health unit secretary was originally responsible for completing the appropriate forms and was not aware until 7/28/26 they were not getting done. SS-A stated she spoke to the unit secretary who stated she thought the social worker was completing the forms. SS-A stated she had not been doing them because she was not told she was supposed to do them nor was she trained how to complete them. During an interview on 7/28/26 at 11:43 a.m., the health unit secretary (HUC) stated she received an email from the facility administrator on 4/7/26 indicating the social worker would be responsible for completing the NOMNC/ABN forms going forward. An email sent on 4/7/26 from the administrator to SS-A, HUC, and other facility employees indicated SS-A was responsible for doing the [Medicare]- B NOMNCs going forward. The email did not mention Medicare part A benefits. During an interview on 7/29/26, SS-A was able to explain the purpose of the NOMNC and ABN form however was unsure how to determine the cost of services that is indicated on the ABN form. During an interview on 7/29/26 at 12:25 p.m., the administrator stated SS-A has always been responsible for completing the NOMNC forms and the HUC completes the ABN forms. The administrator stated she would expect the NOMNC and ABN forms to be done completely and in a timely manner. During a follow-up interview on 7/29/26 at 12:30 p.m., the HUC confirmed she had not completed the NOMNC or ABN forms since April 2026. She confirmed R4 and R31 did not (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive them. A policy titled Medicare Denial Procedure dated 2/27/24 indicated the facility provides a notice of Medicare denial to Medicare beneficiaries in a timely manner to inform them that Medicare is not likely to provide coverage for specific items or services that are the subject of the notice. The policy indicated the Medicare Denial Notice will be delivered no later than 48 hours prior to discharge from services and far enough in advance to allow the Medicare Beneficiary sufficient time to consider their options and make an informed choice regarding their right to appeal the decision that Medicare will not cover specific services. The policy further indicated if the beneficiary will continue to stay in the care center, the facility would provide the NOMNC and SNF ABN which is the demand bill portion.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure a resident possessed the clinical knowledge and skills required to monitor and manage an indwelling medical device independently, and failed to clinically assess the resident's competency to self-manage the device. This affected 1 of 1 resident (R12) reviewed for an indwelling biliary drain. Findings include: R12's quarterly Minimum Data Set (MDS) assessment, dated 5/15/26, indicated R12 was cognitively intact with no symptoms of delirium. R12 had no history of behaviors. The MDS indicated R12 was independent with activities of daily living, bed mobility, transfers, and ambulation. R12's ability to bathe self was not assessed. The MDS indicated R12 had a history of post traumatic stress disorder, aphasia (struggle expressing words). R12's diagnoses list included kidney disease, chronic gall bladder inflammation, history of gallstones with obstruction, stroke, and history of falls. R12's care plan included gall bladder disease with biliary tube (a tube inserted in the gall bladder to allow fluids to drain) and drainage bag. The care plan indicated daily site care, change drainage bag every two weeks, drink extra fluids, monitor insertion site, and R12 emptied drainage bag independently. R12's nursing assistant care plan indicated R12 may ask for assistance with upper body dressing due to drainage bag, and R12 was independent with morning routine. R12's provider orders included dressing changes to insertion site twice a day, monitor site for signs of infection, and specific site care supplies. During observation and interview on 7/27/26 at 11:47 a.m., R12 was observed with a biliary tube inserted into his right side below the ribcage. The tubing extended across his abdomen and was attached to a drainage bag clipped to his upper left chest-positioning the drainage bag above the level of the tube's insertion site. During an interview, R12 stated he has had the tube for 6 years and empties it himself, but noted it does not always drain well. R12 stated that facility staff explicitly told him to hang the bag on his upper left chest. During observation and interview on 7/28/26 at 9:22 a.m., R12 was observed lying completely flat in bed. The biliary tube extended from his right side across his body and remained connected to the drainage bag attached to his shirt on his upper left chest. R12 reconfirmed he drains the bag himself. During an interview on 7/28/26 at 2:32 p.m., registered nurse (RN)-B stated nurses provide medications and perform dressing changes to R12's biliary tube. R12 performs all other activities of daily living himself, including emptying the biliary tubes drainage bag. RN-B stated staff do not track the amount of drainage and assess the drainage based on what is collecting in the tube. RN-B pointed to her waistband and stated R12 clips the bag under his shirt. RN-B stated she did not receive any specific training regarding management of a biliary drain and does what the order says to do. During interview on 7/28/26 at 3:13 p.m., nurse manager (NM)-A stated R12 was admitted with the biliary tube and has had it for 5-6 years. Nursing staff do site care however R12 manages emptying and changing of the drainage bag. R12 will inform staff if there are issues. NM-A stated R12 clips the bag under his shirt and usually tacks it in his undergarments. NM-A was unaware R12 keeps the drainage bag clipped by his left upper chest stating R12 never used to put it that high. NM-A stated the fluid would not be draining properly if the drainage bag was that high. During an interview on 7/28/26 at 4:00 p.m., the facility medical director (MD) stated prior to admitting to the facility, R12 was living independently in a hotel and was unable to care for himself. The MD stated the biliary drainage bag should hang below the opening for proper drainage and secured on his side properly to prevent it from being dislodged. The MD stated she feels having the drainage bag stored in R12's left upper chest would not be a problem if he was standing because the tube itself would hang below the opening before following to R12's left upper chest. The MD stated securing the bag to the left upper chest would pose a problem if R12 was laying down because the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluid would flow back into his gallbladder. During an interview on 7/28/26 at 4:26 p.m., the facility assistant director of nursing/infection preventionist (ADON) stated R12 lived alone prior to admission to the facility and managed the biliary drain independently. The ADON stated nursing staff observe the drainage each day with dressing changes. The ADON stated she did not recall if the facility did any specific education with staff to care for the drainage bag or what to look for. She also stated she was unable to find an assessment indicating R12 was knowledgeable enough to care for the drainage bag and report concerns independently. During an interview on 7/28/26 at 4:28 p.m., the director of nursing (DON) stated R12 was living independently in poor living conditions prior to being admitted to the facility. The DON stated R12 has had the biliary drain for a number of years and was caring for it independently. She stated facility nursing staff perform site care and she is 99% sure nursing staff also empty the drainage bag. The DON stated staff perform dressing changes to the site twice a day so it would be best if nursing empties it. The DON stated the drainage bag should be stored lower than the insertion site and believes R12 tucks the bag into his pants. the DON stated she was not aware of any assessments performed to determine if R12 could safely empty and care for his biliary drain. The DON stated it is facility staff's responsibility to empty the bag, monitor drainage, and provide site care unless it is determined R12 is safe to do so himself.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to identify triggers or attempt to identify triggers to avoid potential re-traumatization and failed to develop a care plan to include individualized trauma-informed approaches for 1 of 1 resident (R29) who had a history of trauma. Findings include: R29's comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated R29 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R 29's diagnoses included post-traumatic stress disorder (PTSD), Parkinson's disease without dyskinesia and anxiety disorder. R29's trauma informed assessment dated [DATE] identified R29 as a trauma survivor and no triggers identified to avoid the potential of re-traumatization. R29's current care plan revised on 6/26/26 lacked identification of any PTSD triggers or interventions. During an interview on 07/29/2026 11:18 a.m., registered nurse, (RN)-A stated, if a resident had PTSD, they needed to be assessed for triggers, and those triggers would be documented on the care plan to help better care for the residents. RN-A completed a brief review of R29's care plan and acknowledged lack of trauma informed care plan in place for R29. During an interview on 07/29/2026 11:38 a.m., nursing assistant (NA)-A stated, if a resident had a history of PTSD and had triggers it would be important to know what their triggers were to better care for them. NA-A stated, was aware of R 29's PSTD diagnosis, however, was unable to locate R29's triggers and intervention on the care plan or Kardex. During an interview on 07/29/2026 11:46 a.m., licensed practical nurse (LPN)-A stated, knew of R29's PTSD diagnoses, however, was not aware of any specific triggers and interventions for R29. During an interview on 07/29/2026 12:14p.m., social services, stated had completed trauma-informed care assessment on 04/16/26, however was unaware of the trauma-informed care plan completion responsibility. Facility Policy titled Trauma Informed Care revised on 09/11/23 indicated, care centers will use a universal screening tool to identify previous trauma emphasizing the value of culture and diversity of others. The Screening tool for trauma will be completed as an assessment in the electronic medical record (Trauma-Informed Care: Resident/Trauma-Informed: Responsible Party) by social services (or designee) with the resident and/their representative on admission or when behaviors may indicate past trauma. Care planning of resident centered behavioral health approaches and goals will be completed in response to the screening or when identified on periodic assessment of resident survivor. Care plan goals and approaches will include individual preferences and routines in response to the emotional and psychological need of the resident survivor.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 3 of 5 residents (R2, R29, R31) reviewed for immunizations were offered and/or provided the pneumococcal conjugate vaccine (PCV)20 as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infections. Findings Include: A review of the CDC Shared Clinical Decision-Making document titled PCV20 or PCV21 Vaccination for Adults 65 years or older dated 9/11/24 indicated that adults [AGE] years of age or older have the option to receive supplemental PCV20 or PCV21 if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23. The guidance specified that the determination to administer PCV20 or PCV21 is based on a shared clinical decision-making process between a patient and their healthcare provider, taking into account that an increased risk of exposure to these serotypes may occur among people living in nursing homes or other long-term care facilities. The document further noted that if the provider and patient decide PCV20 or PCV21 is appropriate, one dose should be given at least 5 years after the patient's last pneumococcal vaccine dose. R2's medical record indicated she was [AGE] years old. R2's Minnesota Immunization Information Connection (MIIC) report indicated R2 received PPSV-23 vaccine on 8/28/18 and PCV13 vaccine 12/2/16. R2's medical record lacked documentation of shared decision making with provider and resident/responsible agent regarding administration of PCV20 vaccination. R29/R29's medical record indicated R29 was [AGE] years old. R29's MIIC report indicated R29 received the PCV13 on 12/2/16 and PPSV 23 on 11/2/15. R29's medical record lacked documentation of shared decision making with provider and resident/responsible agent regarding administration of PCV20 vaccination. R31 R31's medical record indicated R31 was [AGE] years old. R31's MIIC report lacked record R31 received any pneumococcal vaccines. R31's vaccination consent form indicated R31 had previously received the pneumococcal vaccines however no indication of which vaccination was received. R31's medical record lacked any documentation of a shared clinical decision-making process with the provider and the resident or their responsible agent regarding the administration of the PCV20 vaccination. During an interview on 7/29/26 at 12:50 p.m., the facility assistant director of nursing (ADON) stated R31's family member thought R31 had received the pneumococcal vaccine however the IP confirmed she did not follow-up with the family member which pneumococcal vaccination R31 received. The IP also confirmed neither she nor the facility provider have discussed providing R2, R29, or R31 the PCV-20 vaccine. During a follow-up interview on 7/30/26 at 10:19 a.m., the ADON stated she reviews a residents MIIC report upon admission and offer vaccines to residents who are eligible. The IP again confirmed R2, R29, and R31 have not been offered the PCV20 vaccine. A policy titled Resident Immunizations dated 6/16/26 indicated All residents will be offered vaccinations based on the Centers for Disease Control recommendations and physician orders. The adult immunization schedule, prepared by the CDC, will be utilized to ensure residents are offered and encouraged to accept the appropriate vaccinations. This schedule will be maintained per the CDC website. The policy indicated an immunization history will be taken upon admission including checking the MIIC website. Any immunizations that are not current or unknown vaccination histories will be shared with the attending physician and appropriate physician orders obtained. The resident's immunization history will be documented and maintained in the resident's electronic record. Vaccine information statements will be provided to the resident and/or representative prior to administration of the vaccination. The determination to vaccinate or not will be documented in the electronic medical record. Administration of the pneumococcal vaccine are based on CDC guidelines. Administered immunizations will be documented in the EMR and on the MIIC website.		