STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Paynesville	407 East State Highway 55 Paynesville, MN 56362

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to properly store and label individual portions of food to reduce the risk of foodborne illness. This had the potential to affect all 48 residents who resided at the facility. Findings include: During initial kitchen tour on 4/6/26, at 10:19 a.m., with dietary manager (DM): in the freezer part of walk-in cooler there was a gray plastic bin located on the second shelf on the left were multiple individual portions of meals in round cardboard containers with plastic covers. The tub contained: 3 bowls chicken broccoli soup - dated 1/13/261 bowl chicken broccoli soup - dated 12/31/252 bowls potato soup - undated1 bowl chicken pot pie soup - dated 11/15/251 bowl chicken dumpling soup - dated 11/2/252 bowls egg bake - dated 11/18/251 bowl chicken salad - dated 5/2/251 bowl marinara sauce - dated 11/28/25 On the shelf below the bin were two opened bags containing 4 chicken drummies; one with an opened date of 11/4/25 and a full bag dated 10/18/25. Additionally, there was an opened bag of bacon bits dated 11/2/25.Second kitchen tour 04/08/2026 at 10:38 a.m., DM stated above listed items were past expiration and had been removed from freezer. DM stated the bowls were good for 2-3 months once placed in the freezer. DM stated she used an app to determine expiration dates and only one dietary staff had access to use the same app. Bowls were labeled with opened on date but should also have a use by date. DM stated staff defaulted to 3 months if they were unsure of the use by date. DM agreed the current method put the residents at risk of being served expired food. During interview on 4/08/26, at 2:30 p.m., Administrator (Admin) stated he was unaware of the dating process for leftovers in the kitchen. Admin agreed if an app was being used to identify expired foods, it would be necessary for all staff to have access to the app to avoid serving outdated food and prevent a potential food borne illness outbreak.A policy was requested for food storage, however lacked specific instructions on the labeling and storing leftovers and identifying expired foods.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a Level II pre-admission screen (PASARR) had been completed prior to admission for 1 of 5 residents (R7) reviewed for Level II PASARR screening for mental illness. Findings include: R7's comprehensive Minimum Data Set (MDS) dated [DATE] Indicated R7 was severely cognitively challenged, and had the following diagnoses: Anxiety, Bi-Polar disorder, Post Traumatic Stress Disorder, Unspecified Dementia and Unspecified mental disorder. R7's Minnesota Senior Linkage line pre-admission screening results dated 7/1/24, indicated R7 met the requirements for a mental illness OBRA Level II assessment and was required to have an OBRA Level II assessment prior to being admitted to any nursing facility. R7's complete medical record was reviewed on 4/7/26 and lacked documentation of results of a Level II assessment. During interview on 4/8/26 at 8:46 a.m., Director of Nursing (DON) provided copy of the completed Level II assessment and stated the facility had received it on 4/7/26 after state agency surveyors had requested a copy. DON stated the facility did not have the completed Level II assessment at the time of R7's admission and therefore did not include the findings when creating an initial plan of care. DON expected staff to obtain all required Level II assessments prior to a resident's admission and stated it was important to have the information at the time of admission to best meet the needs of residents with mental health issues. A policy was requested but not provided.

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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 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 observation and interview, the facility failed to submit complete and/or accurate data for staffing information based on payroll and other verifiable data during 1 of 1 quarter (Quarter 2) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include:Review of the Payroll Based Journal (PBJ) [NAME] Report 1705D identified the facility had one star staff rating and four or more days within the quarter with no Registered Nurse (RN) hours during the first quarter of fiscal year 2026, which included dates between October 1, 2025, through December 31, 2025.Review of daily staff schedules and facility staffing report during quarter 1 indicated adequate levels of RN coverage throughout the first quarter of fiscal year 2026. Therefore, the data submitted in the payroll-based journal (PBJ) report to the Center for Medicare and Medicaid Services (CMS) was inaccurate. During interview on 04/08/2026 at 1:47 p.m., Director of Nursing (DON) stated corporate staff was responsible for submitting PBJ report to CMS, and until recently had been completed and submitted by the previous owner. DON stated both she and the Administrator (Admin) had made multiple attempts to assist in fixing the error, however, they had been unsuccessful. During interview on 04/08/2026 at 2:30 p.m., Admin stated he had been trying to get someone in the corporate offices to address this for months to correct the issue, but it remained a problem. Admin provided copies of email exchanges with corporate offices indicating an awareness of the issue and attempts to correct. A policy was requested but not provided