STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R6) reviewed for urinary tract infections (UTI). Findings include: R6's significant change Minimum Data Set (MDS) dated [DATE], identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R6's diagnoses included hypertension, renal insufficiency, thyroid disorder, arthritis, non-Alzheimer's dementia, depression, respiratory failure, chronic respiratory failure with hypoxia, mononeuritis multiplex, morbid obesity and dependence on supplemental oxygen. R6's face sheet, print date of 4/9/25, included a diagnosis of urinary tract infection (UTI). R6's electronic health record indicated the following UTI history: 10/30/24 - was diagnosed with a UTI and was started on Cephalexin (antibiotic) 500 mg every 12 hours for seven days. 11/15/24 - was diagnosed with a UTI and was started on Bactrim (antibiotic) 800-160 mg twice daily for ten days. 12/10/24 - was started on methanamine hippirate (antibacterial medication)- one gram twice daily for recurrent UTI's. 1/9/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days 2/11/25 - was started on a cranberry supplement 500 mg twice daily for recurrent UTI's 3/20/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days. R6's physician orders, print date of 4/9/25, indicated an order for methenamine Hippurate (antibacterial medication used primarily to prevent and treat urinary tract infections) - one gram by mouth twice daily for recurrent UTI's. (continued on next page)

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
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's care plan, print date of 4/9/25, did not include R6's urinary tract infection, R6's history of urinary tract infections, goals of treatment, and interventions allowing the nurse to assess the intervention's outcome and potentially revise care based on the resident's status. During interview on 4/10/25 at 9:58 a.m., registered nurse (RN)-A clinical coordinator stated the clinical coordinators are responsible for updating the resident's care plans. RN-A stated if a resident had an history of UTI's it should be included in the care plan so staff are watching for signs and symptoms and could recognize them earlier to treat the UTI sooner. RN-A stated it was important to include history of UTI's on the care plan to help with implementation of interventions or staff being aware so symptoms could be recognized and acted on. RN-A confirmed R6's care plan did not include that R6 had a history of UTI's or goals/interventions to prevent and treat UTI's. During interview on 4/10/25 at 10:06 a.m., director of nursing (DON) stated each discipline of practice completes their section on the resident's care plan. DON stated medical or nursing related issues were completed by the clinical coordinators. DON stated she would expect staff to update the RN clinical coordinator with any changes with the resident. DON stated if a resident had a history of UTI's, she would expect that to be included in their care plan. DON stated it was important so staff can know that R6 is susceptible to UTI's and that all steps are taken such as, thorough cares, increasing fluids and noticing the symptoms that R6 displays with UTI's so we can respond quickly with treatment. The facility Care Plans, Comprehensive Person-Centered policy, dated 2/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practical able physical, mental, and psychosocial well-being. c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. d. Incorporate identified problem area. e. Incorporate risk factors associated with identified problems f. Reflect the resident's expressed wishes regarding care and treatment goals. g. Reflect treatment goals, timetable and objectives in measurable outcomes. h. Identify the professional services that are responsible for each element of care: i. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. j. Reflect currently recognized standards of practice for problem areas and conditions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation and document review, the facility failed to ensure the required nurse staffing information was posted daily for 3 of 3 days reviewed. This had the potential to affect all 48 residents residing in the facility, visitors and staff who may wish to view the information. Findings include: During observation on 4/7/25 at 11:32 a.m., the nurse staffing information was posted on wall inside the entrance of the facility. However, the posted nurse staffing information was dated for 4/7/25 and 4/8/25. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted on specific units of the facility labeled Team Leader LPN [licensed practical nurse] [NAME] Oaks and Charge Team Lead LPN Whispering Pines During observation on 4/8/25 at 8:00 a.m., same nurse staffing information remained posted on wall from 4/7/25. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted under the section labeled Team Leader LPN [NAME] Oaks and Charge Team Lead LPN Whispering Pines During observation on 4/9/25 at 8:15 a.m., the nurse staffing information dated for 4/9/25 and 4/10/25 was posted. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted under the section labeled Team Leader LPN [NAME] Oaks and Charge Team Lead LPN Whispering Pines During interview on 4/10/25 at 8:52 a.m., business office manager (BOM) confirmed she completed the daily staff postings and posts them to let staff know where they are working and she tried to keep it updated as much as possible. BOM stated she posts two days at a time. BOM confirmed there were TMA's listed under the Team leader LPN section, the facility name was not included on posting and the current census was not reflected on posting. BOM stated it was important to have the correct information so families and resident know the numbers of staffing the facility was running with, ensures we had the correct number of staff on so if something happened, we would have proof that we were properly staffed. BOM stated it was important to have staff listed under the correct titles because it could be false information and give off the wrong information as there are many things an LPN could do that a TMA could not legally do. During interview on 4/10/25 at 10:11 a.m., director of nursing (DON) stated the daily staff posting was for compliance. DON stated TMA's should not be listed under the LPN section as that was false documentation and families could think the TMA was able to do things that an LPN should do. DON confirmed posting did not contain the facility name or the current census. The facility's Posting of Nursing Hours policy, dated 4/25, indicated the facility posted nursing staffing data was to make staffing information readily available for resident and visitors at any given time. Staffing personnel and/or their designee will post the following daily information in a prominent area of the facility: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Facility name 2. Current date 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 1 resident (R35) reviewed for medication errors. This failure resulted in actual harm for R35 when she had a fall, sustaining a minor head injury, developed tachycardia (abnormally fast heart rate) and became hypertensive (abnormally high blood pressure) which required ongoing monitoring in the emergency department (ED). The facility had implemented appropriate corrective action prior to the onsite investigation, therefore the deficiency is being cited at past non-compliance. Findings include: R35's quarterly Minimum Data Set (MDS) dated [DATE], identified R35 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R35's diagnoses included non-traumatic brain dysfunction, hypertension, diabetes mellitus, non-Alzheimer's Dementia, anxiety disorder, nocturia, and generalized edema. A facility report to the State Agency (SA) on 3/24/25, indicated on 3/24/25 at 7:45 a.m., R35 received another resident's medications, and had been sent to the hospital. On 3/24/25 at 8:30 a.m., a progress note indicated R35 had an unwitnessed fall at 8:15 a.m., where R35 obtained a laceration above her left eyebrow. R35 was sent to the emergency room (ER) for further evaluation based on recent received medication that was intended for another resident. On 3/24/25 at 8:45 a.m., a progress note indicated R35 was administered wrong medications. Order written for evaluation and treatment at the ER. R35's Blood Pressure and Pulse Summary dated 4/8/25 indicated on 3/24/25, R35 had a blood pressure (BP) of 179/123, and heart rate (HR) was 129 at 8:05 a.m. At 8:15 a.m. R35's BP was 169/105 and HR was 114 beats per minute (bpm). Normal blood pressure is 120/80 and normal pulse is 60-100 bpm. R35's Emergency Department Note dated 3/24/25, indicated R35 was given the following medications the morning of 3/24/25: acetaminophen 650 milligrams (mg) - two tabs, aspirin (blood thinner) 81 mg , calcium 600+vitamin D 600-400 mg, citalopram hydrobromide 20 mg (selective serotonin reuptake inhibitor), lisinopril 40 mg (blood pressure medication), metoprolol succinate ER 200 mg (blood pressure medication), omeprazole 20 mg (heartburn medication), primidone 250 mg (seizure medication), torsemide 20 mg (diuretic), and vitamin D 1000 units. R35's hospital History and Physical Summary dated 3/24/25, indicated R35 was accidentally given the wrong medications on the morning of 3/24/25. R35 had the following symptoms: weakness and hypertension. Computed tomography (imaging test that detects injuries) of head was performed with no abnormalities noted. Per note, pharmacy was updated and advised the metoprolol would peak at about 2:00 p.m. that afternoon so R35 needed to have her blood pressure and heart rate monitored frequently. ER doctor indicated monitoring of vitals should be able to be accomplished at the care center and parameters were given for when to notify if needed. ER final diagnoses included: minor head injury and accidental drug ingestion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/24/25 at 1:15 p.m., a progress note indicated R35 returned from the ER at approximately 11:00 a.m., vital signs were obtained upon her return with BP being 193/103 and 191/118 and her HR was 75 and 76 bpm. New orders indicated for staff to administer morning scheduled doses of duloxetine, potassium, preservision, and sucralfate; staff to hold morning doses of Tylenol, lisinopril (ACE inhibitor- heard medication), protonic (for gastric reflux, and furosemide (diuretic) and resume usual medications orders on 3/25/25; and for staff to check BP and HR hourly until 4:00 p.m., then every four hours for the next 24 hours - and to notify on call provider if R35's heart rate is less than 50 bpm or systolic blood pressure (SBP) is less than 100. On 3/25/25 at 9:48 a.m., registered nurse (RN)-B sent a message to nurse practitioner stating Resident was given another residents medications yesterday and following meds had a fall in the bathroom. We sent her to the ER; Resident per ER was to have BPs every hour until 4:00 p.m. and then every four hours for 24 hours. BPs and HRs were not consecutively gotten. Staff was to update MD on call is SBP was less then 100 or HR was less then 50 bpm. All SBPs that were taken were greater then 140 and all HRs were greater than 65. BPs and HRs were taken hourly upon readmission at 11:00 a.m. until 2:00 p.m. then not again until 10:40 p. m., then has been every four hours since then. On 3/25/25 at 1:03 p.m., nurse practitioner responded that staff could go back to standard vital checks with no further monitoring needed. On 4/9/25 at 3:36 p.m., RN-C stated on 3/24/25, during the morning medication pass, she set up multiple residents' medications in med cups that she initialed with their first and last name initials and placed them in the top drawer of the medication cart to administer at a later time. RN-C stated when she went to administer R35's medications, she gave R35's another resident medications as she had mislabeled the medication cup. RN-C stated when she realized the error, she notified the RN clinical coordinator immediately who instructed her to wait 30 minutes and to then obtain R35's vital signs as that would be when the medications could start working. RN-C stated R35 then fell approximately 30-40 minutes after she had administered her the wrong medications. RN-C was removed from passing medications and had to complete an education module on medication administration. RN-C was told she needed to leave the facility pending investigation. RN-C had since been re-educated and was now aware that pre-preparing medications was not an acceptable practice, and she would not be doing it in the future. On 4/9/25 at 4:47 p.m., consultant pharmacist (Pharm D) stated after she reviewed the medications R35 received in error, she was concerned about R35's blood pressure as she received high doses of blood pressure medications and seizure medication. Per email from Pharm D to the facility: Based on the medications received, particularly higher doses and multiple medication classes, I do think it is likely that the fall was a result of the medication error. Primidone alone has an onset of as little as 30 minutes. Many of the other medications have a peak within an hour. Pharm D stated it would not be acceptable for nurses to prepare more than one person's medications at one time ever. Pharm D stated due to the multiple significant medications that were not R35's, she would consider this a significant medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N Elm Street Sauk Centre, MN 56378

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 0760 Level of Harm - Actual harm Residents Affected - Few	On 4/10/25 at 10:11 a.m., the director of nursing (DON) stated the process of passing medications staff was to follow the medication rights, and to prepare medications for one resident at a time. The policy was not followed by RN-C on 3/24/25. The facility had reviewed the medication administration and medication incident policy, revised the medication administration standards policy, reviewed R35's care plan, started medications administration audits, and education was provided to nurses in regard to medication pass expectations. DON stated it was not appropriate for staff to pre-set-up medications and place them in the top drawer of the medication cart to administer at a later time as that can lead to a medication error. The facility Medication Administration policy dated 2/2025, identified staff administering medication would perform ongoing monitoring of the resident's response to medications administered. Medications are to be administered in a timely manner, accurately and in a way to allow for maximum benefit. Personnel administering medications practice safe medication administration including the correct process for resident identification. Medications will not be prepared without the intent to administer, known as pre-pouring or pre-setting. The facility implemented corrective action to prevent recurrence by 3/28/25 when the facility completed the following: Reviewed and revised medication administration policies, provided education to all staff members responsible for medication administration, which included administration of medications and ensuring the six rights of medication administration was being followed, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview, and document review on 4/10/25.