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	03/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident was treated with dignity and respect for 1 of 3 residents (R26) reviewed for dignity.Findings include:R26's annual Minimum Data Set (MDS) dated [DATE], identified R26 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R26's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), arthritis (inflammation of the joints causing pain and stiffness), Alzheimer's disease (a progressive brain disorder that causes memory loss and cognitive decline), and spinal stenosis (narrowing of the spinal canal that can cause pain or nerve pressure). During observation on 3/3/26 at 11:28 a.m., R26 was observed sitting in a wheelchair in the dining room. A mechanical lift sling remained under R26. The leg straps of the sling were positioned upright between R26's legs and were visibly protruding upward. The straps were visible to others in the dining room. During observation on 3/3/26 at 4:12 p.m., R26 was observed in the chapel seated in a wheelchair with the mechanical lift sling still in place. The sling leg straps were again observed sticking straight up between R26's legs and were visible to other residents and staff in the area. R26's comprehensive care plan, printed 3/5/26, indicated it was acceptable to leave the sling underneath R26 for safety and potential skin alteration; however, the care plan did not include instructions regarding positioning of the sling while R26 was seated in common areas. During an interview on 3/05/26 at 8:31 a.m., nursing assistant (NA)-B stated the Hoyer sling was typically left under R26 while seated in the wheelchair. NA-B stated the sling should have been tucked in as much as possible around the sides, so it was not visible. NA-B further stated the leg straps should have been removed from between R26's legs and tucked in as much as possible so they were not noticeable in order to maintain R26's dignity. During an interview on 3/05/26 at 8:34 a.m., registered nurse case manager (RN)-A stated the Hoyer sling was care planned to be left under R26, and staff should have ensured the sling was not folded or positioned off to the side. RN-A stated the sling should have been tucked in as much as possible. RN-A further stated the leg straps should have been removed from between R26's legs and tucked under the legs. RN-A confirmed the straps should not have been left between R26's legs or sticking up, as this would have been a dignity concern. During an interview on 3/05/26 at 11:25 a.m., the director of nursing (DON) stated if the Hoyer sling was left under R26 while seated in the wheelchair it would typically be care planned, as removing the sling could cause more harm to R26 due to rigidity. The DON stated staff were expected to tuck the sling in as much as possible, so it was not highly visible. The DON further stated the leg straps should have been removed from between R26's legs and tucked in, or a lap blanket could have been placed across R26's lap to cover the sling. The DON confirmed leaving the straps between R26's legs would have been a dignity concern. Review of the facility policy titled Quality of Life - Dignity, dated 10/25, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The policy further indicated that residents shall be treated with dignity and respect at all times.

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 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 record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's clinical status for 1 of 3 residents (R3) reviewed for MDS accuracy.Findings include:R3's significant change Minimum Data Set (MDS), dated [DATE], identified R3 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by physical injury), hypertension (high blood pressure), diabetes mellitus (high blood sugar due to insulin problems), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), overactive bladder (frequent and urgent need to urinate), sacrococcygeal disorder (condition affecting the sacrum or tailbone), chronic pain (long-lasting pain), obstructive sleep apnea (breathing repeatedly stops during sleep), pain in the thoracic spine (pain in the middle portion of the spine), hallucinations (seeing or hearing things that are not present), retention of urine (inability to fully empty the bladder), and insomnia (difficulty sleeping). The MDS indicated R3 experienced one fall with a major injury since admission. Review of R3's progress notes and incident documentation dated 8/28/25 through 11/30/25, indicated R3 experienced falls on 8/28/25, 9/2/25, 9/5/25, 9/7/25, 9/18/25, 9/23/25, 9/25/25, 10/5/25, 10/20/25, 10/22/25, 10/24/25, 10/28/25, and 11/3/25. Documentation did not identify R3 sustained a major injury, such as a fracture, dislocation, closed head injury with altered consciousness, or another injury requiring extensive medical intervention as a result of any one of these falls. During an interview on 3/4/26 at 3:41 p.m., the MDS Coordinator (MDS) confirmed the MDS indicated R3 experienced a fall with major injury and stated R3 did not sustain a major injury from the fall and that it must have been accidentally coded incorrectly. During an interview on 3/4/26 at 3:52 p.m., the Director of Nursing (DON) stated R3 had not experienced a fall with a major injury since admission on [DATE]. The DON stated MDS assessments should always be double-checked to ensure they included accurate and correct information before submission. Review of the facility policy titled Minimum Data Set, Management of, Long Term Care, dated 1/25, indicated the facility would ensure the MDS was accurately and comprehensively completed.

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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** Based on observations, interviews and document review, the facility failed to comprehensively develop a resident care plan for 1 of 1 resident (R48) reviewed for pain management.Findings Include: R48's diagnoses report, print date 3/5/26, included the following: other displaced den's fractures (a break in the upward bony projection of the second cervical vertebra, causing severe neck pain and instability), cervicalgia (pain in the cervical spine (neck), sprain of right acromioclavicular joint (located at the top of the shoulder). R48's quarterly minimum data set (MDS) dated [DATE] indicated R48 was independent with activities of daily living, frequently experienced pain, with a BIMS (brief interview for mental status) of 13 - cognitively intact. A review of R48's Care Area Assessment (CAA), dated 11/04/25, documented the following:[R48] is an 80 [year old] male admitted to facility for continued rehab and pain control after a hospital stay in St. Cloud and subsequent swing bed stay in Sauk Centre hospital after a fall causing Type III fracture of odontoid process, closed. Other diagnoses include [hypertension],chronic A-fib, cognitive impairment. Resident is alert and oriented, with short-term forgetfulness. Vital signs stable. Vision adequate with use of eyeglasses, minimal difficulty hearing, some wax present in bilateral ears on admission. No dental issues noted. Resident has no ROM limitations except for his neck, C-collar in place to keep resident from moving neck until it is healed. Resident is independent with eating, rolling left and right; set up assist needed for oral hygiene; supervision needed for toileting hygiene, upper body dressing, personal hygiene, sitting to lying, lying to sitting, sit to stand, chair to bed to chair transfers, ambulation, substantial [maximum] assist for putting on/taking off footwear. Resident is continent of bowel, utilizes MiraLAX 17 grams daily and senna-docusate 2 tabs twice daily due to narcotic use, has BM?s 4-6X weekly. Resident is continent of bladder, voids 3-4 times daily. Staff provide A1 with toileting tasks. Resident is at risk for falls d/t history of falls, medication use. Does have history of X2 falls at home. No falls in facility at this time. Falls prevention interventions in place, see care plan. Resident is at risk for pressure ulcer formation d/t potential for bladder incontinence, decreased activity, pain and narcotic use, use of C-collar. Resident is independent with mobility in bed, has pressure reduction mattress on bed, dressings in place under edges of C-collar for padding and skin breakdown prevention. Resident does [complained of] pain that varies at times dependent on position of neck even with C-collar on. Describes pain as aching, sharp, tender, shooting and dull at times. He does report difficulty sleeping and waking often due to pain. Pain relief includes scheduled and prn pain medication, frequent position changes, cold packs, distraction which seem to be effective. Will continue to monitor for any issues or complaints. Will proceed to care plan.During interview on 3/02/26 at 3:58 p.m., R48 stated prior to admission he was home doing laundry in the basement. When R48 took his laundry basket to the top of the stairs, he threw the basket onto a shelf causing him to loose balance and fell backwards down the stairs. R48 stated he felt sore, but needed to get to a family gathering in Sauk Centre. R48 stated he drove himself to the reunion, afterwards driving himself to the emergency room in Sauk Centre, where was diagnoses with the shoulder and neck fractures. R48's Medication Review Report (print date of 3/05/26) included the following medications: Tizanidine HCL (Zanafex) 2 milligrams (mg) 1 tablet orally every 8 hours as needed (short-acting, centrally acting skeletal muscle relaxant) for displaced DENS fracture with routine healingVoltaren External Gel 1% (diclofenac sodium) topical cream apply to all joints three times a day (nonsteroidal anti-inflammatory topical cream)Acetaminophen 500 mg - 2 tablets orally three times a day for displaced DENS fracture with routine healingLidocaine External Patch 4% - apply to right shoulder as needed (PRN)- removed after 12 hourscholecalciferol 25 micrograms (mcg) give one tablet every day - displaced DENS fracture with routine healingAscorbic acid oral tablet 500 mg chewable (vitamin C) once a day - displaced DENS fracture with routine healing R48's medication administration records (MAR) for February 2026 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and March 1-5, 2026 documented R48 had only been taking the the ascorbic acid, acetaminophen, and cholecalciferol. R48's MARs indicated resident had not been requesting his as needed (PRN) medications of Tizanidine HCL, Lidocaine External Patch 4%, nor Voltaren External Gel 1%. R48's Pain Evaluation - Assessment - V3 (dated 1/23/26), indicated R48 was currently experiencing pain, described as sharp and tender, which varied during the day, with the facility comments as follows:resident has had decrease in pain with healing of fracture, worked with PT [physical therapy] on right shoulder pain. Resident is in process of weaning brace from fracture and occasionally gets a sharp pain when turninghead at night. Pain goes away with repositioning. R48 stated no longer needing narcotic pain medication. Has PRN medication available. No referrals indicated. R48's comprehensive care plan (print date 3/04/26) lacked evidence the facility had comprehensively developed R48's care plan to include his pain concerns. During interview on 3/04/26 at 12:51 p.m., care manager (RN)-A, after reviewing R48's care plan stated R48's care plan lacked documentation of resident's pain issues. The MDS coordinator (RN)-B stated when R48 was admitted to the facility, he was on a different unit and assessed and care planned by a newer care manager. RN-A stated when R48 was transferred to her unit in January 2026, she should have reviewed R48's care plan more closely. RN-B stated R48's care plan did mention resident was on pain medications, however after further review, pain [medications] were mentioned was under R48's nutritional problem. In an interview on 3/5/26 at 9:27 a.m., director of nursing (DON) stated it was the expectation, when residents have been comprehensively assessed, all areas of concerned identified, would be comprehensively care planned, so that facility staff would be aware of the issues of each resident. In review of the facility policy, entitled: Care Plans, Comprehensive Person-Centered (effective date 02/2025) indicated the following in section 8:8. 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 practicable 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. describe any specialized services to be provided as a result of PASARR [Preadmission Screening and Resident Review] recommendations;e. include the resident's stated goals upon admission and desired outcomes;f. include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such desire;g. incorporate identified problem areas;h. incorporate risk factors associated with identified problems;i. build of the resident's strengths; j. reflect the resident's expressed wishes regarding care and treatment goals;k. reflect treatment goals, timetables and objectives in measurable outcomes;l. identify the professional services that are responsible for each element of care;m. aid in preventing or reducing decline in the resident's functional status and/or functional level;n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. reflect currently recognized standards of practice for problem areas and condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were revised to reflect current conditions and interventions for 1 of 2 residents (R13) reviewed for Enhanced Barrier Precautions.Findings include:R13R13's annual Minimum Data Set (MDS), dated [DATE], identified R13 had moderate cognitive impairment and required assistance with some activities of daily living (ADLs). R13's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by physical injury), non-Alzheimer's dementia (cognitive decline not related to Alzheimer's disease), strength), low back pain (pain in the lower spine), obesity (excess body weight), and nonrheumatic mitral valve insufficiency (leakage of the mitral heart valve). The MDS indicated R13 was at risk for developing pressure ulcers/injuries and did not have an unhealed pressure ulcer at that time. R13's comprehensive care plan, with a print date of 2/24/26, included the following interventions, which were initiated on 11/5/25 and remained active:Resident was on Enhanced Barrier Precautions per CDC recommendations for a Stage 2 pressure ulcer.Remain free from multidrug-resistant organisms (MDROs).Use gown and gloves for high-contact resident care activities.Make personal protective equipment (PPE) available outside of the room.Post clear signage indicating required precautions and PPE.Provide education to the resident and visitors. Review of progress notes indicated:On 1/8/26 at 4:07 p.m., R13 was evaluated by the MNDOTA Health Wound Clinic Nurse Practitioner, and right and left ischial tuberosity wounds were identified as healed.On 1/15/26 at 2:12 p.m., skin assessment revealed no open areas, with reddened but blanchable skin.On 1/22/26 at 12:00 p.m., previously affected areas remained healed with intact, blanchable skin and no new concerns identified. Review of R13's electronic medical record (EMR) identified R13 previously had wounds to the right and left ischial tuberosities, which had resolved on 1/8/26. However, review of the comprehensive care plan revealed continued inclusion of interventions for enhanced barrier precautions (EBP) related to wound care, despite the wounds being resolved and EBP no longer being implemented. During observation on 3/2/26 at 1:16 p.m., no EBP precautions were in place for R13, including no signage posted outside the resident's room and no personal protective equipment (PPE) cart present. During an interview on 3/3/26 at 12:52 p.m., R13 stated prior sores to the buttocks had healed approximately one month earlier and confirmed no current open areas. During a joint interview on 3/4/26 at 3:37 p.m., the registered nurse case manager (RNCM) and infection preventionist (IP) stated R13 had no current wounds and confirmed the wounds had resolved on 2/5/26. They further stated R13 was no longer on EBP precautions and acknowledged the care plan should have been updated to remove these interventions. They indicated it was important for the care plan to accurately reflect current interventions to ensure staff followed appropriate care and understood the resident's overall needs. During an interview on 3/4/26 at 3:49 p.m., the Director of Nursing (DON) stated care plans were to be updated with any changes in a resident's condition or care needs. The MDS process, including quarterly assessments, should prompt review and revision of the care plan. The DON further stated updates should be reflected in the care plan and any related signage should be removed immediately when no longer applicable. The DON indicated the care plan was an ongoing document intended to guide staff in providing appropriate care based on the residents' current needs. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated 2/2025, indicated a comprehensive, person-centered care plan with measurable objectives and timelines was to be developed and implemented for each resident. The policy further indicated resident assessments were ongoing and care plans were to be revised as the residents' condition changed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented to prevent potential contamination of oxygen equipment when oxygen tubing was observed lying on the floor with the nasal cannula prongs touching the floor for 1 of 2 residents (R3) reviewed for infection control.Findings include:R3's significant change Minimum Data Set (MDS) dated [DATE], identified R3 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R3's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by physical injury), hypertension (high blood pressure), diabetes mellitus (high blood sugar due to insulin problems), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), chronic pain (long-lasting pain), and obstructive sleep apnea (breathing repeatedly stops during sleep). During observation and interview on 3/02/26 at 2:42 p.m., R3 stated she wore oxygen only at nighttime and required staff assistance to apply and remove the nasal cannula. The nasal cannula was observed lying on the floor with the prongs, which are inserted into the resident's nose when in use, touching the floor. During observation on 3/03/26 at 11:14 a.m., oxygen tubing was observed on the floor at the end of R3's bed with the nasal cannula prongs touching the floor. During observation on 3/03/26 at 2:15 p.m., oxygen tubing remained on the floor at the end of R3's bed next to the oxygen concentrator with the nasal cannula prongs touching the floor. During observation on 3/04/26 at 8:30 a.m., oxygen tubing noted on the floor at the end of R3's bed next to the oxygen concentrator with the nasal cannula prongs touching the floor. During observation on 3/04/26 at 12:16 p.m., oxygen tubing remained on the floor at the end of R3's bed next to the oxygen concentrator with the nasal cannula prongs touching the floor. R3's order summary report, dated 3/5/26, indicated an order initiated on 12/10/25 for supplemental oxygen at 2 liters per minute (LPM) at NOC (bedtime) for nocturnal hypoxia identified during a sleep study. During interview on 3/04/26 at 1:46 p.m., nursing assistant (NA)-A stated R3 required assistance removing the oxygen in the mornings as R3 only wore oxygen at night. NA-A stated the nasal cannula should be draped over the end of the bed or the oxygen concentrator when not in use and should not touch the floor. During interview on 3/04/26 at 2:50 p.m., licensed practical nurse (LPN)-A stated oxygen tubing should never touch the floor due to infection control concerns. During a joint interview on 3/04/26 at 3:41 p.m., registered nurse case manager (RN)-A and MDS registered nurse (RN)-B stated R3 wore oxygen at night, and the oxygen tubing should not be on the floor. RN-A and RN-B stated allowing oxygen tubing to touch the floor was an infection control concern. During interview on 3/04/26 at 3:52 p.m., the director of nursing (DON) stated oxygen tubing should not be placed on the floor when not in use due to infection control concerns. Review of the facility policy titled Infection Prevention and Control, dated 1/2026, indicated the facility was to maintain equipment in a sanitary condition and implement appropriate infection control practices to prevent contamination and the spread of infection.