

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Cura of Sandstone		STREET ADDRESS, CITY, STATE, ZIP CODE 109 Court Avenue South Sandstone, MN 55072	
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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the facility staff administered medications without significant medication errors for 4 of 21 residents whose medication error reports reviewed. R4's Order Summary dated 3/01/26, indicated R1 had seizure disorder and diffuse traumatic brain injury with loss of conscious of unspecified duration. R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 had severe cognitive impairment, received anticonvulsant medications and had seizure disorder. Findings include: R4 R4's Order Summary dated 3/01/26, indicated R4 had seizure disorder and diffuse traumatic brain injury with loss of conscious of unspecified duration. R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 had severe cognitive impairment, received anticonvulsant medications and had seizure disorder. R4's Physician Orders dated 3/01/26, included Dilantin (anti-seizure medication) give 150 milligrams (mg) via gastrostomy (G)-tube twice daily (BID) for seizure disorder. Lacosamide (anti-convulsant) Solution give 10 milliliters (ml) via G-tube three times daily for post traumatic epilepsy. A Medication Error Report dated 3/18/26, indicated on 3/17/26 R4 had received an omission of Lacosamide 10 ml, at 5:11 p.m. The Report indicated medication was documented as given in the Medication Administration Record (MAR) but was not found until the next shift sitting in medication cabinet in a medication cup. The Medication Error Report indicated the cause was a distraction that caused the error and staff were to be more mindful, and there was no pattern. Plan of correction was to not leave medications in room and to double check prior to leaving before the end of the shift. The report indicated the physician was notified by the portal. An additional medication error for R4 indicated on the same date of 3/17/26, Dilantin 150 mg was to be given at 5:07 p.m., but was found on the next shift sitting on the medication cabinet in a medication cup. The Medication Error Report indicated the cause was a distraction that caused the error and staff were to be more mindful, and there was no pattern. Plan of correction was to not leave medications in room and to double check prior to leaving before the end of the shift. The report indicated the physician was notified by the portal. This resulted in two significant medication errors for R4 related to her seizure medications. R4's Seizure Report indicated the last seizure R4 had in March 2026 was 3/12/2026, which was not when she missed her seizure medication on 3/17/26. During interview on 7/15/26 at 12:45 p.m., the facilities pharmacist consultant stated any medication that involves a seizure medication is considered a significant medication error. R4 Evaluation and Management visit with primary physician dated 3/25/26, did not indicate any mention of the medication errors, or laboratory orders to follow up on the seizure medications missed. R2 R2's Care Plan dated 11/03/25, indicated R2 had subdural hematoma (collection of blood between the brain and it outer covering), traumatic brain injury, craniotomy (a surgical operation where a doctor temporarily removes a piece of the skull to reach the brain) and g-tube placement. Staff were directed to administer medications as ordered. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245454	Facility ID: 245454 If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Cura of Sandstone		STREET ADDRESS, CITY, STATE, ZIP CODE 109 Court Avenue South Sandstone, MN 55072	
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 - Minimal harm or potential for actual harm Residents Affected - Some	Observe for effectiveness and adverse effects and update doctor (MD) as needed. ^ R2 Hospital admission Orders dated 5/18/26, indicated to give propranolol (affects blood flow through arteries and veins) 20 mg give one tablet every eight (8) hours. ^ R2's Medication Error Report dated 5/14/26 at 5:00 p.m., indicated R2 had an order for propranolol 20 mg oral every 8 hours, hold for systolic blood pressure (BP) <100 or heart rate (HR) <60. ^ Order not given on night (NOC) when scheduled at 5:00 a.m. and BP/HR not assessed to hold dose. Morning (AM) shift administered at 7:09 a.m. ^ During interview on 7/15/26 at 4:51 p.m., the director of nursing (DON) stated she had to work the night shift on 5/14/26 and was up for 24 hours and was tired. ^ The DON stated she did not pass the medications at 5:00 a.m. and left them for the day shift nurse coming on. ^ The DON stated she left a sticky note on the medication cart notifying the day shift nurse and left the facility because she was exhausted. ^ During interview on 7/15/26 at 1:00 p.m., facilities pharmacy consultant stated he was concerned with the medication given late due to the patient's medication history and risk of blood clots and felt this was a significant medication error. ^ R5 R5's quarterly MDS dated [DATE], indicated R5 had hemiplegia (paralysis or severe weakness affecting one side of the body), seizure disorder and received anti-convulsant medications. ^ R5's Medication Error Report dated 4/22/26 at 8:41 p.m., indicated R5 had an order for Klonopin (used to treat panic disorders and certain seizure disorders) 1 mg orally (PO) in the evening (HS). ^ The report indicated the medication was never removed from the medication drawer. ^ The report did indicate the physician was notified and plan of correction was to slow down, review rights, and double check before signing off meds. ^ The report indicated no adverse reaction occurred. R5's MD visit was on 5/05/26, which indicated she had seizure disorder and anxiety and received Klonopin 1 mg at HS and has not had any seizures. ^ R8 R8's quarterly MDS dated [DATE], indicated R8 was cognitively intact, and did not receive anticonvulsant medication. ^ R8's Physician Orders dated 5/01/26, indicated R8 received Keppra 250 mg BID (twice daily) for seizure disorder. R8's Physician summary dated 5/01/26, indicated The patients Epilepsy unspecified, intractable (treatment-resistant, refractory or poorly controlled), without status epilepticus as evaluated today. ^ Diagnosis puts at high risk for decompensation (rapid functional decline). ^ Diagnosis for morbidity and mortality. ^ And received Keppra (anti-epileptic) and was overall stable, no recent seizure activity. ^ R8's Medication Error Report dated 4/24/26 at 6:27 p.m., indicated R8 received Keppra 150 mg documented in medication administration record (MAR) as administered, but not punched out of bubble pack. ^ The report indicated the physician was notified and no adverse reactions occurred. ^ What occurred was trying to go too fast and staff needed to slow down, make sure checks are done properly, review the seven rights and do double checks. ^ During interview on 7/15/26 at 1:20 p.m., the pharmacy consultant stated he was not provided with the medication errors in the quarterly QAPI meeting and was informed he will in the July 2026 meeting. ^ The Pharmacist stated there have been changes in the staff and figured that was why, but he also stated this facility has had a history of medication errors and felt all of the medication errors were felt to be significant medication errors. During interview on 7/16/26 at 12:28 p.m., the regional nurse consultant stated there is room for improvement for tracking, trending and the follow up for the charting of medications errors. ^ In addition, the nurse consultant stated the charting for medication needs to be better. ^^ Facility policy, Medication Error-Long Term Facility effective 4/2025, indicated A detailed account of the incident must be recorded in facility approved format such documentation must include, but is not limited to, the time the incident the name strength and dosage of the medication, the residents reaction to the medications, any treatment administered the provider name date and time they were notified, notification of resident and/or representative, and known or suspected contributing factors that led to the incident, resident receiving incorrect medication. ^ Medication errors will be considered (continued on next page)		

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: 245454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Cura of Sandstone		STREET ADDRESS, CITY, STATE, ZIP CODE 109 Court Avenue South Sandstone, MN 55072	
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 - Minimal harm or potential for actual harm Residents Affected - Some	for the need for additional reporting under vulnerable adult reporting. ^All medication error reports will be reviewed by DON and quarterly at Quality Assurance meeting.		