STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sandstone	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate infection control while providing laundry services, as well as failing to maintain an effective Infection Prevention and Control Program specific to infection surveillance. The facility's system did not track culture results, organisms identified, or transmission-based precautions (TBP) initiated to ensure residents received appropriate treatment and infection control measures were maintained. This had the ability to affect all 36 residents. In addition, the facility failed to ensure proper glove use and hand hygiene during care for 1 of 1 resident (R8) during completion of ADL cares.Findings include: Laundry Tour: During a laundry room tour on 4/8/26 at 7:16 a.m., other staff (O)-B was observed sorting dirty laundry without wearing gloves and a gown. O-B lifted dirty laundry from a bin, holding the laundry against themselves, and putting the laundry in a washing machine. During a laundry room tour on 4/8/26 at 7:25 a.m., O-B was observed removing clean laundry from a dryer, folding and hanging resident clothing. During an interview on 4/8/26 at 7:25 a.m., the laundry manager stated that staff should be wearing gloves and a gown when handling dirty laundry. They stated a concern for cross contamination with clean laundry. Facility Departmental (Environmental Services) Policy – Laundry and Linen dated 4/2026 instructed employees sorting or washing laundry must wear a gown and gloves and to consider all dirty laundry to be potentially infectious. Infection Surveillance Program: Review of the Infection Surveillance Reports (ISR) dated 1/26, 2/26, and 3/26 showed documentation included resident name, room number, onset date, infection type, such as urinary tract infection (UTI), signs and symptoms, status, and pharmacy order. However, the log lacked documentation of the date cultures were obtained, organisms identified from culture results, whether organisms were resistant to prescribed antibiotics, and any TBP initiated. Review of R13's urine culture results dated 3/2/26, identified the susceptibility profile was consistent with probable extended-spectrum beta-lactamases (ESBL), an infection that is resistant to common antibiotics. During an interview with the infection preventionist (IP) and registered nurse (RN)-C, both working as (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assistant directors of nursing, on 4/8/26 at 10:25 a.m., the infection preventionist (IP) stated the facility did not track organisms on their ISRs and that cultures results were in the resident's record. The IP stated they were not aware that R13's culture results dated 3/2/26 indicated probable ESBL and indicated knowing the organism was important to place the resident on the appropriate precautions to prevent the spread of infection to others. RN-C reviewed R13's record, confirmed the culture results, and that according to the culture results R13 should have been put on contact precautions. During an interview on 4/8/26 at 3:55 p.m., the director of nursing (DON) stated they expected that the infection organism was tracked with their infection surveillance program. They stated it was important to track the organism to prevent the spread of infection. Facility Transmission-Based Precautions policy dated 1/26, instructed that contact precautions were implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact, including ESBL. Facility Surveillance for Infections policy dated 1/2026, identified gathering surveillance data as part of the facility's Infection Control Program. R8: R8's annual Minimum Data Set (MDS) dated [DATE] indicated R8 had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated R8 was always incontinent of bowel and bladder, and dependent of staff for toileting hygiene. R8's care plan undated, indicated R8 had an alteration in elimination r/t incontinent of urine and bowel. interventions included to check and change every two hours and as needed, along with provide peri cares with incontinence episodes. During an observation on 4/7/26 at 2:50 p.m., nurse assistant (NA)-G entered R8's room and told R8 he was going to check to see if he was dirty and if so, change his brief and clean him up. NA-G washed his hands and placed his gloves on. NA-G gathered wipes, cream, and a new brief from the bedside table. R8's Pants were lowered, the brief was opened up and confirmed R8 was dirty with urine. NA-G removed R8's old dirty brief and washed the front of his peri area with wipes. R8 was rolled to the right side and NA-G cleaned the buttock region. Rolled to the right side. Barrier cream was then applied to R8's buttock. With the contaminated gloves still on, NA-G then placed the new brief on R8 and secured it in place and pulled pants back up. NA-G then opened the bedside drawer and returned the cream back the drawer with the contaminated gloves still on. Finally, NA-G gathered all the trash and walked out of the room, to the trash room, threw away the trash and finally removed the contaminated gloves and washed his hands. During an interview on 4/7/26 at 3:00 p.m., NA-G stated the only time he changed his gloves when going from dirty to clean parts of peri care was when stool had gotten on the gloves. Otherwise, the gloves would be wiped down when peri wipes and finish the job without changing the gloves. Gloves were removed and hands were washed after all the dirty items were thrown into the trash. During an interview on 4/8/26 at 11:23 a.m. the infection preventionist (IP) stated the facility had started hand hygiene audits about a 1.5 weeks ago. Staff were expected to remove gloves after completing peri-care and use hand sanitizer. They should take off their gloves before touching clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	items and sanitize. Soap and water were to be used for enteric precautions, before/after using the bathroom, c. diff and before/after eating. To prevent the spread infection. During an interview on 4/8/26 at 2:43 p.m., the DON stated all staff should change gloves when doing cares anytime they change from dirty parts of the process to clean parts of the process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow care planned interventions necessary to prevent an avoidable accident from occurring for 2 of 5 (R30, R14) residents reviewed for falls and accidents. In addition, the facility failed to ensure the safety of a resident with suicidal ideations and not following provider orders for safety precautions for 1 of 5 residents (R2) reviewed for accident hazards. Finally, the facility failed to evaluate a resident with an increased risk of aspiration for 1 of 1 residents (R8) reviewed for accident hazards.Findings include: R30: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had moderate cognition, and diagnoses included cerebral infarct (stroke). R30 required assist of 1 staff, gait belt (a belt used as a safety device to support patients when walking) and a 4-wheeled walker for ambulation to/from the bathroom. R30 did not ambulate outside of the bedroom or bathroom. R30's undated Care Plan, identified R30 had potential for injury related to impaired mobility, impaired cognition. R30 was impulsive and consistently wouldn't ask for assistance or use the call light, had poor safety awareness, self-transferred and self-toileted. Interventions included anti-slip strips on the floor in front of the recliner, dycem under wheelchair cushion and on recliner chair, for slipping and fall prevention, encourage to wear appropriate footwear and keep call light within reach. The plan identified R30 had a self-care deficit related to diagnosis of stroke. Interventions included PER THERAPY R30 [NAME] be an assist of 1 for transfers and ambulation with a 4 wheeled walker. Staff were to always use a gait belt when transferring or ambulating R30. R30's Therapy Communication dated 2/12/26, identified R30 may be assist of 1 staff for transfers and ambulation with a 4 wheeled walker. Gait belt at all times when transferring or ambulating. Patient requires extra time to complete tasks and max cues for safety. During observation on 4/7/26 at 6:53 p.m., the director of nursing (DON) and R30 exited the bathroom and were walking towards R30's recliner. DON was walking alongside and not touching R30. R30 was pushing a 4 wheeled walker. R30 was not observed wearing a gait belt around his waist. During interview on 4/7/26 at 7:08 p.m., the DON stated a resident's transfer status is listed on their care plan and Kardex and staff can view them in the computer system. DON stated during R30's transfer, R30 used a 4 wheeled walker, although staff had not used a gait belt. The DON stated R30's care plan identified staff were to use a gait belt with R30 during all mobility/transfers. The facilities Transferring/Ambulating A Resident policy dated 1/26, identified a transfer belt (gait belt) should be used when assisting a resident who requires physical assistance with a transfer unless another piece of equipment such as a standing lift or full mechanical lift is used. R14: R14's Significant Change MDS dated [DATE] indicated R14 was significantly cognitively impaired. R14's diagnoses included unspecified dementia, unspecified disorientation, atrial fib, and hypertension. MDS section GG indicated R14 needs moderate assistance with dressing and minimal (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with walking. R14's care plan dated 4/8/26, identified: Self-care deficit related to diagnosis of dementia, interventions included: ambulation: 1 staff assist with belt and walker. R14 was not safe to ambulate independently. dressing: 1 staff assist R14 had impaired cognitive function related to diagnoses of dementia, disorientation, and forgetfulness, interventions included: Remove from harmful situations. Repeat instructions several times, as needed Potential for falls related to diagnosis of dementia, and use of cardiac, antidepressant, narcotic, and diuretic medications. R14 was impulsive, didn't consistently ask for help or use call light, had poor safety awareness, self-transfers, and self-toilets despite not being safe to do so. Interventions included to encourage R14 to wear appropriate footwear/shoes. During an observation on 4/8/26 at 7:10 a.m., R14 was ambulating in the hallway to a chair in the dining room with nursing assistant (NA)-B. R14 was wearing black socks without grippers and no shoes. During an interview on 4/8/26 at 7:42 a.m., nursing assistant (NA)-B stated they had helped R14 get dressed and walked with R14 to the dining room, and they had not noticed that R14 just had socks on their feet. NA-B stated R14 should wear shoes when walking, and they were concerned R14 could slip if not wearing shoes or non-slip socks. NA-B stated they would apply non-slip footwear to R14's feet immediately. During an interview on 4/8/26 at 11:35 a.m., registered nurse (RN)-C stated R14 was at risk for falls and should wear gripper socks or shoes when walking to prevent slipping. RN-C stated they would expect staff to be aware of R14's footwear prior to a walk. During an interview on 4/8/26 at 3:14 p.m., the DON stated when staff provided minimal assistance with walking per R14's care plan, they expected staff would ensure R14 had shoes or non-slip socks on and used their walker, and that staff remained close to R14 and provided verbal cuing. The DON stated concerns for slipping and increased fall risk if R14 was not using non-slip footwear when walking. Facility policy Safety and Supervision of Residents dated 11/2021, instructed staff to identify any specific accident hazards or risks for individual residents and ensure interventions were implemented consistently to reduce accident risks. Facility policy Fall Management - Long Term Care dated 6/2025, instructed staff to implement interventions on the resident's care plan to minimize the risk of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2: R2's quarterly MDS dated [DATE], identified intact cognition and diagnoses of major depressive disorder with psychotic symptoms, bipolar disorder, hallucinations, parkinsonism, insomnia, chronic pain syndrome, and mild cognitive impairment. R2's MDS also indicated delusions, physical and verbal behavior toward others, and wandering behavior. R2 was dependent for transfers and was able to propel his own wheelchair with partial assist. R2's care plan included a focus statement dated 3/6/26, indicating R2 was at risk for alteration in mood related to suicide ideation and thoughts they would be better off dead. The care plan didn't include interventions for keeping cords from R2's reach. R2's electronic medical record (EMR) identified the following timeline: 6/20/25, a provider order to monitor for suicidal ideations and verbalizations of self-harm. 2/1/26, a progress note identified R2 was making comments about getting guns, shooting people, comments about finding a cord to commit suicide. Provider notified and gave order to send to the emergency department if making suicidal ideations. 2/1/26, a provider order to keep all cords out of resident's reach due to suicidal ideation every shift. 4/6/26, a care plan and Kardex update identified to keep cords out of R2's reach. During an observation 4/6/26 at 3:03 p.m., R2 had two soft-touch, pancake-style call lights with cords approximately 15 feet long plugged into the wall and draped to his chair room, there were several electric cords plugged into two televisions and a cable box, on the windowsill there was a small fan plugged in, and a cellphone-style charging cord. Next to R2's bed on a bedside table, there was a charging strip with a cord charging an electric razor, another cellphone-style charging cord, and a refrigerator plugged in. On the wall on the other side of the bed there was a cord hanging from a light fixture at the head of the bed down to about the level of the mattress. R2 was observed in his wheelchair rolling around the room with the ability to reach all of the 11 different cords. During an interview on 4/6/26 at 6:56 p.m., NA-E stated she was familiar with R2 and his care, she stated she was aware of him making suicidal statements because she had heard in report the other weekend. NA-E stated R2 had safety checks for self-transferring. On 4/6/26 at 7:02 p.m., licensed practical nurse (LPN)-B demonstrated in the EMR that R2 had hourly safety checks for behavior, items he shouldn't have, like trash bags and watching him with the cords, and recent suicidal ideation. LPN-B stated it was normally the aids who do more of the rounding, she tried to help out when she could. During an interview on 4/6/26 at 7:06 p.m., RN-B stated they didn't know of R2 having recent suicidal ideations or threats. RN-B confirmed the treatment administration record (TAR) identified to keep all cords out of R2's reach due to suicidal ideation, and to monitor for suicidal ideation. During an observation on 4/6/26 at 7:27 p.m., R2 was in his room in a wheelchair, moving about his room and all 11 cords were still in the same places. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/6/26 at 7:33 p.m., the DON stated they have had residents who have made suicidal statements, but they currently didn't have any. The DON stated she was familiar with R2's behaviors, he wasn't suicidal any longer, adding he could hallucinate about things and people, was paranoid and thought people were stealing his things, or that they're out to get him, R2 did have a diagnosis of bipolar disorder, and was followed by in-house psychiatric service. The DON stated she thought R2's mood lately had been good, and after reviewing the EMR stated the last time R2 had made suicidal statements was 2/1/26, and they did get an order for him to be evaluated in the emergency room if he continued to make statements. Immediate interventions were to initially place him on one-to-one supervision, then 30-minute checks, and to remove all cords from his room, except for the call cords. The DON stated she supposed you could wrap a call cord around yourself; they were pretty long. The DON stated they should be having ongoing interventions for a resident who makes suicidal statements. At 8:29 p.m., the DON stated the order to remove cords from his room was active and didn't have an end date, the nurses were signing off on the TAR that he shouldn't have cords within his reach. The DON added that the aids wouldn't know he shouldn't have cords because it wasn't on the care plan. The DON confirmed an active order should be followed. During an interview on 4/6/26 at 8:38 p.m. NA-D stated R2 can't have a phone charging cord, electric razor cords, or electric recliner cord. During an observation on 4/7/26 at 12:02 p.m., R2 was in his room in a recliner with the footrest up. A trash can with no liner was observed in R2's room, as well as all 11 cords observed yesterday with an additional item, a corded telephone with an approximately eight-foot-long cord had been plugged in and set on the windowsill. Both soft-touch call cords are plugged into the wall and strung over a wire shelving unit next to R2 in the recliner. During an interview on 4/7/26 at 1:34 p.m., NA-C stated she knew R2 was on suicide watch and 30-minute checks, but he's never made any statements to her, and she really didn't know why he was on suicide watch. During an interview on 4/7/26 at 1:39 p.m., NA-A stated she was familiar with R2 and knew he was on suicide watch because a while ago, he had said something, but she wasn't sure what. NA-A stated no one had ever told her R2 had said anything about cords, she didn't know anything about it. During an interview on 4/7/26 at 5:34 p.m., NA-A stated she knew how to care for residents by looking at their Kardex and care plan and under the communication tab to review for new resident changes before she started her shift. NA-A confirmed she had done that today when she started her shift at 2 p.m. and didn't see anything new for R2. NA-A stated R2 was on half-hour safety checks, she would just make sure he was doing ok and not agitated and talk with him. NA-A reviewed the Kardex and stated it said to keep cords out of his reach, NA-A stated this was new and she didn't know about this. NA-A stated she wanted to go check R2's room, upon entering NA-A stated there were lots of cords in here, and started to remove the fan and R2 said, hey what are you doing?. NA-A stated she was going to check with management before he got too upset. At 5:47 p.m., NA-A stated the corporate administrator would be checking into it. At 6:08 p.m., NA-A stated the administration removed most of R2's cords and was doing some research on the bed cords. During an observation on 4/8/26 at 11:51 a.m., all the cords except the television cords and one call light have been removed from R2's room. The 15-foot-long call light cord had been wrapped with a pool noodle and duct tape, which was clean and in good repair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/26 at 3:28 p.m., RN-C, an assistant director of nursing, stated R2 was living in a different room at the time they got the order to keep cords out of his reach and she had modified his previous room but wasn't sure what happened with the cords after he moved to the new room. RN-C stated she wouldn't expect to find cords in his reach when staff were signing off that they were keeping them out of his reach. During an interview on 4/8/26 at 4:17 p.m., the DON stated staff could see the care plan and orders and would have expected they would have taken them out of R2's reach, the risk would be R2 could get a hold of a cord and hurt himself if he were in that mindset. R8: R8's annual MDS dated [DATE] indicated R8 had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated R8 was on a mechanically altered diet as a resident. R8's care plan undated, indicated a potential for altered nutritional status due to hospice. interventions included serve a mechanically altered textured diet and to observe, document, and report and signs or symptoms of dysphagia like pocketing, choking, coughing and holding food in mouth. The care plan lacked interventions of monitoring and assist with meals. R8's provider order dated 3/17/25, indicated to discontinue (DC) regular diet with thin liquids and start mechanical soft diet with slightly thickened liquids R8's provider orders dated 3/19/25, indicated to DC the slightly thickened liquids and start a mechanical soft textured solid food diet with thin liquids. Review of R8's progress notes from 3/10/25 to 3/27/26, were reviewed and indicated the following: on 3/14/25 at 5:38 p.m., R8 took a drink and choked immediately after the drink. Resident placed on meal monitoring until evaluation by administration could be completed. on 3/18/25 at 3:18 p.m., a new order received from hospice to start a mechanical soft with slightly thickened liquids. on 3/19/25 at 5:15 p.m., R8 refused thickened liquids hospice notified of resident complaint of thick liquids. The chart lacked documentation to why thickened liquids were needed or what could happen if the liquids were not thickened. on 3/20/25 at 1:48 p.m., a new order received to DC slightly thickened liquids and start thin liquids. The chart lacked any documentation education occurred related to the need for thickened liquids or a risk verses benefit form was completed by either the resident or the representative. on 1/12/26 at 12:14 p.m., R8 was eating lunch and started choking/coughing on a piece of meat and then ended up vomiting. Staff would monitor for signs and symptoms (S/S) of aspiration. the notes lacked information the guardian was notified of the choking and change of condition. on 2/26/26 at 12:20 p.m., resident coughed with food in his mouth at mealtime. Resident to be monitored at mealtime and assisted until speech/swallow eval could be completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/26 at 12:52 p.m., R8 started coughing with food in his mouth. at the mealtime. R8's face became red and appeared to be having difficulty chewing and swallowing. Attempted to listen to his lung sounds as it had sounded like R8 had aspirated, but R8 was making bear growling noise, which made it hard to listen. Hospice was notified. The documentation lacked information related to notifying the guardian of the change in condition. During an observation on 4/7/26 at 12:32 p.m. R8 was observed in the dining hall eating lunch. There were no staff with him to monitor and assist him to eat his meal. During an interview on 4/8/26 at 9:38 a.m., NA-B stated R8 frequently coughed when he eats. They get the nurse when it happens, but it does seem like they are not changing anything to stop it. NA-B stated the staff was not aware of a need to monitor and assist R8 with meals. During an interview on 4/8/26 at 10:18 a.m., hospice RN-E stated if a resident had concerns about aspiration, then we would work with the facility to either have a dietician or speech therapy evaluate the resident for diet and aspiration concerns. Hospice was aware R8 had an increased risk of aspiration and there were current concerns of aspiration when he ate. RN-E reviewed the notes from visits on 1/12/26 and 2/26/26 and confirmed they had been called to perform a visit due to concerns with aspiration and choking when he ate. There had been no conversation related to dietician consults or speech therapy consults to get an appropriate diet ordered for resident safety but there should have been. During an interview on 4/8/26 at 10:46 a.m., licensed practical nurse (LPN)-E stated She started working with R8 when the choking occured on 2/26/26. I was not R8's primary care nurse and the primary care nurse was the one who communicated with the hospice team. I am not sure if there was a request for speech therapy eval. During an interview on 4/8/26 at 12:28 p.m., RN-C stated if there was a resident with concerns related to aspiration and choking then a speech eval should be obtained to make sure the appropriate diet is ordered to keep the resident safe from choking. If the resident was on hospice then either hospice or the facility staff could obtain the order for speech therapy. RN-C reviewed R8's order history and stated there had never been an order for speech therapy to evaluate swallowing since arrival in the facility. During 4/8/26 at 2:43 p.m., the director of nursing stated anytime there was a concern of choking and aspiration, the expectation was the staff would obtain a speech therapy evaluation order for the resident safety. Facility aspiration precautions policy was not received.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify family/guardian when a resident had a change of condition. This affected 1 of 1 (R8) resident reviewed for change of condition.Findings Include: R8's annual Minimum Data Set (MDS) dated [DATE] indicated R8 had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated R8 was on a mechanically altered diet.R8's care plan undated, identified a potential for altered nutritional status due to hospice. Interventions included a mechanically altered textured diet and to observe, document, and report and signs or symptoms of dysphagia like pocketing, choking, coughing and holding food in mouth.R8's provider orders dated 3/19/25, identified a mechanical soft textured solid food diet with thin liquids.Review of R8's progress notes from 3/19/25 to 3/27/26 were reviewed and indicated the following:From 3/19/25 to 1/11/16, there was no documentation of concerns related to aspiration.on 1/12/26 at 12:14 p.m., R8 was eating lunch and started choking/coughing on a piece of meat and then ended up vomiting. Staff would monitor for signs and symptoms (S/S) of aspiration. The notes lacked information the guardian was notified of the choking and change of condition.On 2/26/26 at 12:52 p.m., R8 started coughing with food in his mouth at the mealtime. R8's face became red and appeared to be having difficulty chewing and swallowing. Attempted to listen to his lung sounds as it had sounded like R8 had aspirated, but R8 was making bear growling noise, which made it hard to listen. Hospice was notified. The documentation lacked information related to notifying the guardian of the change in condition.During an interview on 4/8/26 at 10:46 a.m., licensed practical nurse (LPN)-E stated anytime there was a change in condition such as change in vital signs, mental state, or breathing the family member/guardian should be notified related to a change in condition of the resident. LPN-E stated choking on food and concerns related to aspiration were included on the list of items that would trigger a call to family member or guardian. LPN-E confirmed she was the staff member in the dining hall on 2/26/26 at 12:52 p.m., when R8 had the observed choking and concerns related to possible aspiration. LPN-E stated hospice was called but that the guardian was not called at that time.During an interview on 4/8/26 at 12:10 p.m., LPN-D stated nursing staff should call and notify both the hospice team and the guardian when there is a change in condition such as breathing issues or aspiration/choking on food while eating.During an interview on 4/8/26 at 12:54 p.m., registered nurse (RN)-B stated both family and hospice should be called when there is any kind of change of condition in the resident so they are aware of the situation and can be part of the care planning for the resident. Conversations would occur related to change in diets and possibly the need to send to emergency room for evaluation.During an interview on 4/8/26 at 2:43 p.m., the director of nursing stated when a resident had a choking episode and concerns with possible aspiration, after the resident is stable, the nurse should notify the provider, the guardian/family member, and hospice if the resident is on hospice.Facility policy Change in a Resident's Condition or Status dated 7/25, indicated when a change in resident condition occurred the nurse would notify the resident's provider on call and the resident's representative when there was a significant change in the resident's physical, emotional, or mental health or when there was a need to alter the resident's medical treatment significantly.

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	245454	A. Building B. Wing	04/08/2026

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Cura of Sandstone	109 Court Avenue South Sandstone, MN 55072

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents with constipation received assessment, effective intervention and notification of the provider for 2 of 5 residents (R2, R3) reviewed for unnecessary medications. This deficient practice had the potential for resident discomfort and medical complications related to constipation. Findings include:R2:R2's quarterly minimum data set (MDS) dated [DATE], identified intact cognition, a diagnosis of slow-transit constipation and occasional bowel incontinence. R2 was dependent for transfers to the toilet and for toilet hygiene.R2's provider orders included 3/3/26, sennosides-docusate sodium (a stool softener) 8.6/50 milligrams (mg) one tab daily for constipation. Orders activated from facility Standing Orders included prunes, prune juice or bananas apples and pears (BAP) as-needed (PRN) for bowel protocol for three days, milk of magnesia (MOM) 30 milliliters (mL) by mouth one time only for constipation, and Dulcolax suppository (a stimulant laxative)10 milligrams (mg) insert rectally every evening shift for constipation for bowel protocol day one.R2's medication administration record (MAR) for March 2026 identified PRN bowel medications and dietary interventions from Standing Orders were utilized 19 times. R2's MAR from 4/1 to 4/8/26 identified they were utilized seven times.R2's electronic medical record (EMR) from 4/1 to 4/8/26 identified one bowel movement (BM) on 4/5/26. R2's EMR didn't contain evidence of a nurse assessment or notification of provider regarding repeated unsuccessful constipation interventions.During an interview on 4/8/26 at 11:51 a.m., nursing assistant (NA)-B stated R2 needed assistance on and off the toilet, and the aids were responsible for documenting the BM. During an interview on 4/8/26 at 12:36 p.m., registered nurse (RN)-B stated the night shift nurses would run a bowel report and give the day shift a BM list, for example today she had R2 and another resident. RN-B stated the bowel protocol started after two days on no BM, but she will talk to the resident, like R2 today, he will go three days without intervention and has said it was normal for him to go a couple days without going and R2 will also tell her if he thinks he needs something, today he didn't want an intervention. If it had been longer, RN-B stated she would check the orders to see the progressive interventions, and by day five probably administer a suppository.R3:R3's quarterly MDS dated [DATE], identified intact cognition, ability to make her needs known and diagnoses of need medical record. R3 was always continent of bowel and independent with toileting hygiene, and a stand-by assist for transfers.R3's undated care plan, identified a focus statement for altered elimination with interventions to give medications as ordered, observe for effectiveness and adverse effects. To follow the bowel protocol as directed for bowel movements, observe for effectiveness of toileting program, offer toilet every two to three hours, record bowels every shift, and update provider with changes to bowel pattern. R3's care plan also indicated she needed stand-by assist of one as needed for transfers and walked independently with a walker. R3's provider order dated 12/15/22, identified polyethylene glycol powder 17 grams by mouth every 12 hours PRN for constipation. R3's MAR for March and April 2026, identified the medication wasn't used.R3's MAR and bowel monitoring record for March and April 2026, identified the following pattern:3/9, milk of magnesia (MOM) 30 mL by mouth as needed (PRN) for constipation for 3 days daily.3/11, BM documented3/13, prunes, prune juice or BAP one time only for bowel protocol for one day.3/14, MOM 30 mL by mouth PRN for constipation for 3 days daily.3/15, BM documented3/18, prunes, prune juice or BAP one time only for bowel protocol for one day.3/19, MOM 30 mL by mouth one time only for constipation per bowel protocol for one day.3/20, day 4 no BM, utilize PRN medications and dietary interventions for constipation as able until adequate results achieved every day and evening shift for bowel protocol for one day.3/21, day 5 no BM, utilize PRN medications and dietary interventions for constipation as able until adequate results achieved every day and evening shift for bowel protocol for one day.3/23, day 7 no BM, utilize PRN medications and dietary interventions for constipation as able until adequate results achieved every day and evening shift for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel protocol for one day.3/29, prunes, prune juice or BAP one time only for bowel protocol for one day.3/29, BM recorded3/31, BM recorded4/1, BM recorded4/3, prunes, prune juice or BAP one time only for bowel protocol for one day.4/5, MOM 30 mL by mouth one time only for constipation per bowel protocol for one day.4/6, day 5 no BM, utilize PRN medications and dietary interventions for constipation as able until adequate results achieved every day and evening shift for bowel protocol for one day.4/7, BM recordedR3's EMR didn't contain evidence of bowel assessments or provider notification for on-going constipation and PRN use.During an interview on 4/6/26 at 1:57 p.m., R3 stated she thought she was backed up and hadn't gone since last Monday. During an interview on 4/8/26 at 7:41 a.m., NA-B stated she was caring for R3 today, she had just transferred R3 off the bed so she could take her walker and go to the bathroom. R3 would put her light on when she was done. NA-B confirmed she would be responsible for documenting resident BMs.During an interview on 4/8/26 at 9:05 a.m., licensed practical nurse (LPN)-C stated for residents who took themselves to the bathroom the aids or nurses would ask them each shift if they have had a BM and then document it. LPN-C stated only the nurses could see how many days it had been since the last BM.During an interview on 4/8/26 at 1:30 p.m., RN-C, an assistant director of nursing (ADON) stated it was the responsibility of the overnight nurse to run the bowel report and then enter the orders for day shift. RN-C stated their bowel protocol started on day two of no BM, and if a resident had gone five or six days without then she believed you would do the enema, but added the residents had the right to refuse as well. The nurses are pretty good about updating the doctor if they are having constipation issues, she hasn't performed assessments as part of that protocol. It is noted in the care plan that she does also take herself to the bathroom. [NAME] doesn't see the provider was notified. Would expect a prescription PRN to be used. She is known to refuse some meds. RN-C stated there was always the risk of impaction or obstruction, leading to perforation or infection.During an interview on 4/8/26 at 2:07 p.m., the director of nursing (DON) stated her expectation was if staff were using the bowel protocol, and things weren't working they should be reaching out to the provider to update them to see if they need further intervention and would expect them to do an assessment as they were going on without effectiveness.A review of Facility Standing Orders, undated, identified on day two of no BM to give prunes, prune juice or bananas, apples and pears (BAP). On day three, give milk of magnesia (MOM) or lactulose. On day four, give bisacodyl suppository followed by tap water enema if no results. Dosages for the above are, MOM give 30 milliliters (mL) orally as needed daily with a warning not to give if the resident has end-stage renal disease or dialysis, give lactulose instead. For lactulose, give 30 mL by mouth daily as needed. For bisacodyl, give 10 milligrams (mg) suppository rectally daily as needed. For tap water enema, give 500 mL rectally as needed daily.A policy regarding the facility's procedures for bowel management was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to perform a passive range of motion (PROM) program for 1 of 2 (R13) residents reviewed for restorative care.Findings include: R13's annual Minimum Data Set (MDS) dated [DATE] indicated R13 was cognitively intact. Diagnoses included multiple sclerosis (MS) and paraplegia. Section GG indicated R13 had impairment to one upper extremity and both lower extremities. R13's Care Plan undated, indicated a potential for injury related to impaired mobility from paraplegia and MS. Interventions included complete PROM/stretching program once a shift (1 time in morning and 1 time in evening). Copies of PROM program were available at the nurse station 3. R13's PROM documentation from 3/10/26 to 4/8/26 were reviewed and indicated the following:10 shifts were documented as no not performed.14 shifts were documented as not applicable.6 shifts had nothing documented.During an observation on 4/6/26 at 4:23 p.m., R13 was observed to have contractures to her right upper extremity and both of her lower extremitiesDuring an interview on 4/06/26 at 4:23 p.m., R13 stated the staff were always forgetting to do here PROM to her right upper and both lower extremities There have been contractures to those three extremities for some time due to her MS.During an interview on 4/7/26 at 6:18 p.m., nurse assistant (NA)-A stated the care plan told the staff which residents had PROM programs, when they had to be done, and how often. NA-A confirmed R13 was on a PROM program that needed to be done daily during the day shift and evening shift. R13 would refuse the PROM program sometimes. All PROM program documentation was documented on the plan of care and either yes or refused. If the resident refused, the charge nurse needed to be notified. There was no reason to ever document under no or not applicable.During an interview on 4/8/26 at 2:43 p.m., the director of nursing (DON) stated an expectation the NA would perform the PROM program when it was scheduled. A yes or refused would be documented in the plan of care when completed. If the resident refused, then the NA should report that to the charge nurse.Facility policy Restorative Nursing Services last approved 1/14, indicated residents would receive restorative nursing care to help promote optimal safety and independence.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to attempt to elevate the head of bed (HOB) to prevent aspiration for a resident laying flat with tube feeding (TF) running. This effected 1 of 1 (R28) residents reviewed for TFFindings Include: R28's annual Minimum Data Set (MDS) dated [DATE] indicated R28 had moderate cognitive impairment. Diagnoses included abdominal distention and hemiplegia (complete to total muscle loss to one side of the body). R28 received TF with 51% or greater intake received through TF. R28's care plan undated, indicated a nutritional problem related to a diagnosis of hemiplegia. Interventions included to provide TF and water flushes as ordered. R28's care plan also indicated a risk for aspiration related to TF and inconsistent maintenance of HOB greater than 30 degrees secondary to resident preference/refusal. Interventions included ensure resident is positioned with head elevated greater than 30 degrees with feedings, if refusal for HOB elevation is found then hold the tube feeding and resume when safe, staff need to educate on aspiration risk and implement risk-reduction strategies and inform the charge nurse. R28's Order Summary Report dated 2/4/26, indicated an order for Jevity 1.2 vial gastric tube at 30 milliliters per hour. During an observation on 4/7/26 at 1:17 p.m., R28 was observed in bed laying on her back with the HOB flat. The TF was observed running at 30 milliliters per hour continuously. During an interview on 4/7/26 at 1:20 p.m., nurse assistant (NA)-F confirmed R28 was lying flat in bed with the TF running continuously. NA-F stated R28 needed to have the HOB greater than 30 degrees to prevent aspiration, but R28 liked to play with the controls and always lowered her own HOB below the 30-degree mark on her own. NA-F then entered a different resident room without going into R28's room to attempt to raise the HOB greater than 30 degrees or report findings to the charge nurse. During an interview on 4/7/26 at 3:37 p.m., licensed practical nurse (LPN)-D stated all residents with TF were to have the HOB elevated over 30 degrees to decrease the risk of aspiration of the TF. If staff saw the resident with the HOB below the 30-degree level, they should attempt to raise the HOB over 30 degrees and report it to the charge nurse so the resident could be educated. During an interview on 4/7/26 at 3:53 p.m. the director of nursing (DON) stated an expectation was for the staff to attempt to raise the HOB over 30 degrees if the resident was found with the HOB to low. If the resident refused, then the staff should report the refusal to the charge nurse so the charge nurse could educate the resident and if needed do a risk verses benefit. Facility policy Enteral Nutrition last approved on 1/26, indicated possible complications included aspiration and esophageal swelling. The policy did not mention safety precautions to decrease the risk of complications.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 1Number of residents cited: 1Based on interview and document review, the facility failed to ensure the facility antibiotic stewardship program was followed for antibiotic use for 1 of 1 resident (R13) reviewed for antibiotic use.Findings include:R13's annual Minimum Data Set (MDS) dated [DATE], indicated R13 was cognitively intact. R13's diagnoses included multiple sclerosis, dysuria, obesity, diabetes mellitus type 2, paraplegia, and dementia. R13's care plan dated 3/18/26, identified R13 had urinary incontinence and an indwelling catheter.A nursing note dated 2/23/26 at 3:01 p.m., indicated a message was sent on portal to the provider with an update on R13's urinary color, vaginal discharge, and increasing confusion and agitation.R13's provider orders dated 2/23/26 at 7:00 p.m., included Macrobid 100 mg capsule Give 100 mg by mouth two times a day for Dysuria for 7 Days: Macrobid 100 mg by mouth two times a day for 7 days. The medication was discontinued on 3/2/26.R13's progress note dated 2/23/26 at 9:57 p.m., identified that a message was sent on portal to update the provider that R13's symptoms included urinary odor, vaginal discharge, increasing confusion and agitation.R13's Urine Culture Result dated 3/2/26 at 4:06 a.m., identified susceptibility profile is consistent with a probable extended-spectrum beta-lactamases (ESBL), a multi-drug-resistant organism greater than 100,000 colony forming units per milliliter (ml). The antimicrobial susceptibility identified the organism was resistant to cefuroxime. R13's medical record lacked evidence of any established criteria (such as McGreer) being used to determine the presence of infection before an antibiotic was initiated. R13's medical record lacked documentation that non-pharmaceutical interventions were initiated prior to requesting an order for antibiotics.During an interview on 4/8/26 at 10:25 a.m., the infection preventionist (IP) stated nurses needed to identify a minimum of three symptoms, such as fever, change in cognition, or urinary symptoms when suspecting a urinary tract infection (UTI). IP stated R13's medical record reported R13's symptoms were foul smelling urine, discharge, and increased confusion/agitation when staff called the provider on 2/23/26. The IP stated they usually complete a tool such as McGreer's criteria and confirmed there was no documentation that this occurred prior to obtaining antibiotic orders for R13 on 2/23/26.During an interview on 4/8/26 at 10:39 a.m., registered nurse (RN)-C stated the order for the antibiotic Macrobid was received 2/23/26, and they obtained R13's urine sample on 2/25/26, the same day they received the order for the urinalysis. RN-C stated they typically would obtain a urine specimen prior to starting an antibiotic but R13 had a history of refusals and had refused a urine sample.During an interview on 4/8/26 at 3:55 p.m., the director of nursing (DON) stated when a UTI was suspected, they expected staff to monitor symptoms, assess, follow McGreer's criteria, initiate standing orders to start UTI-stat and increase fluids, and update the provider. The DON expected nurses to question a provider ordering antibiotics prior to specimen collection, document the discussion, and report concerns to the DON or IP nurse.The facility policy Antibiotic Stewardship dated 4/2024, identified that inappropriate use of antibiotics affects individual residents and the overall community with the potential for opportunistic infections, drug interactions, and drug-resistant pathogens.