DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 14, 2026

Administrator
Cura of Sauk Centre
425 N ELM STREET
SAUK CENTRE, MN 56378

RE: CCN: 245341
Cycle Start Date: March 5, 2026

Dear Administrator:

On April 23, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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March 24, 2026

Administrator
Cura of Sauk Centre
425 N ELM STREET
SAUK CENTRE, MN 56378

RE: CCN:245341
Cycle Start Date: March 5, 2026

Dear Administrator:

On March 5, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be

acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed.
Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 5, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 5, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	**425 N ELM STREET , SAUK CENTRE, Minnesota, 56378**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 3/2/26 to 3/5/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/24/2026
F0000	INITIAL COMMENTS On 3/2/26 to 3/5/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		03/24/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the	F0550	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan updated to include positioning of the sling, so straps are not visible to promote resident dignity. How the facility will identify other residents having the potential to be affected by the same deficient	04/22/2026

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 reverse for further 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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F0550 SS = D	Continued from page 1 facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: 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 12/26/25, 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	F0550	Continued from page 1 practice. All residents using full body mechanical lift were reviewed and care plans updated to include positioning of sling or residents' preference regarding positioning of sling. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education on Resident Rights/dignity. Care Plan education for Nurses. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON or designee with complete audits 3x week for 3 weeks. Audit will be reviewed at next QAPI and then may continue as needed. The date that each deficiency will be corrected. 4/22/26	

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F0550 SS = D	Continued from page 2 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.	F0550		

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F0550 SS = D	Continued from page 3 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.	F0550		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS Assessment was corrected on 3/4/26 and resubmitted. How the facility will identify other residents having the potential to be affected by the same deficient practice. Review last three months of Quality Measure reports from CMS to see what residents triggered for falls and falls with major injury. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Second check with DON or designee is implemented to ensure the MDS includes accurate and correct information prior to submission. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Second check process will be documented for 3 weeks and reviewed at next QAPI and PRN after as needed. The date that each deficiency will be corrected. 4/22/26	04/22/2026

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F0641 SS = D	Continued from page 4 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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 12/5/25, 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.	F0641		

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F0641 SS = D	Continued from page 5 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 8/28/25. 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.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan for affected resident was updated with pain focus on 3.4.26. How the facility will identify other residents having the potential to be affected by the same deficient practice. Audit completed on all residents to ensure a pain care plan was in place 3.4.26. Another audit completed on 4/2/26 to ensure a pain care plan was in place for all residents. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Care Plans, Comprehensive Person-Centered was reviewed with nursing leadership. Education for RN Leaders on developing a comprehensive care plan. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	04/22/2026

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F0656 SS = D	Continued from page 6 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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 2/5/26 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.	F0656	Continued from page 6 DON or designee will complete a once weekly audit for the next 3 weeks to ensure comprehensive pain management care plan reflects resident care needs. Audit will include all new admissions as current residents have already been audited. Audit will be reviewed at next QAPI and PRN after if needed. The date that each deficiency will be corrected. 4.22.26	

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F0656 SS = D	Continued from page 7 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	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	**425 N ELM STREET , SAUK CENTRE, Minnesota, 56378**

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F0656 SS = D	Continued from page 8 (vitamin C) once a day - displaced DENS fracture with routine healing R48's medication administration records (MAR) for February 2026 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 turning head 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;	F0656		

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F0656 SS = D	Continued from page 9 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; and o. reflect currently recognized standards of practice for problem areas and condition.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan was updated 3.4.26 to reflect residents current condition. How the facility will identify other residents having the potential to be affected by the same deficient	04/22/2026

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F0657 SS = D	Continued from page 10 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: 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: R13 R13's annual Minimum Data Set (MDS), dated 2/5/26, 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.	F0657	Continued from page 10 practice. Audit completed on 3.4.26 on resident infection control care plans for accuracy. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Care Plan, Comprehensive Person-Centered policy reviewed with RN leadership. Education for RN Leaders on timing and revision of care plans. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. IP Nurse or designee to complete audit once a week for three weeks to ensure EBP care plans reflects resident care needs. Audit contains residents currently on EBP and residents recently removed from EBP. Review at quarterly QAPI and PRN after if needed. The date that each deficiency will be corrected. 4.22.26	

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F0657 SS = D	Continued from page 11 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.	F0657		

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F0657 SS = D	Continued from page 12 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.	F0657		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F0880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Corrected immediately for all residents with the potential to be impacted by changing out oxygen tubing and placing command hooks on concentrators to hang up nasal cannula when not in use. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents that utilize oxygen have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Command hooks placed on concentrators for residents that utilize oxygen. Communicated to staff about the use of these hooks for current and future residents. Oxygen Administration LTC policy reviewed and updated procedure with command hooks on concentrators. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	04/22/2026

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F0880 SS = D	Continued from page 13 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the	F0880	Continued from page 13 DON or designee with conduct visual audit 3x a week for three weeks to ensure oxygen equipment is maintained in a sanitary condition to prevent decontamination and spread of infection. Review at next QAPI and PRN after if needed. The date that each deficiency will be corrected. 4/22/26	

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F0880 SS = D	Continued from page 14 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 12/5/25, 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.	F0880		

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F0880 SS = D	Continued from page 15 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.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EAST ADDITION B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/04/2026. At the time of this survey, Cura of Sauk Centre Nursing Home Building 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		03/24/2026

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 reverse for further 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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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cura of Sauk Centre Nursing Home Building 02 is a 1-story building addition with no basement and is fully fire sprinkler protected. Construction was completed in 2023. Construction type is determined to be Type II (000) and has an attic space that has a dry sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors.	K0363	How will you correct the deficiency for the resident(s) affected by the violation? Adjusted door closure and doors closed fully on 3.4.26. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What systematic change will you put into place to prevent the deficiency from reoccurring? Re-education on Life Safety Code for Maintenance Manager. How the facility will monitor its corrective actions to ensure that violations are being corrected and will not recur.	04/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EAST ADDITION B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Sauk Centre	425 N ELM STREET , SAUK CENTRE, Minnesota, 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0363 SS = D	Continued from page 2 Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.5. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/04/2026 at 11:51 AM, it was revealed by observation that the door for the Resident Laundry Room in Whispering Pines did not positively latch when the door was closed. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K0363	Continued from page 2 Audit doors twice weekly for 3 weeks by Maintenance Manager or designee. Findings will be brought to next QAPI meeting. Following QAPI review, audits may be completed as needed. The date that each deficiency will be corrected. 4/22/26	
K0923 SS = D Bldg. 02	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K0923	How will you correct the deficiency for the resident(s) affected by the violation? Oxygen supplier brought in holders for oxygen tanks on 3.4.26 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What systematic change will you put into place to prevent the deficiency from reoccurring? Re-education on Life Safety Code for Northwest Respiratory Representative. How the facility will monitor its corrective actions to ensure that violations are being corrected and will not recur. Audit oxygen rooms once a week for 3 weeks by DON or designee. Results will be brought to next QAPI Meeting.	04/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EAST ADDITION B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

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K0923 SS = D Bldg. 02	Continued from page 3 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain storage of gas cylinders per NFPA 99 (2012 edition), Healthcare Facilities Code, sections 11.3.2.6, and 11.6.2.3(11). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/04/2026 at 11:44 AM, it was revealed by observation that 4 small oxygen bottles were being stored in the Oxygen Storage Room that were not secured by chains or supported in a proper cylinder stand or cart for the size of the bottles. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K0923	Continued from page 3 Findings will be reviewed and audits will be completed as needed. The date that each deficiency will be corrected. 4/22/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **03 - NURSING HOME MA...** B. WING	**03/04/2026**

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K0000 Bldg. 03	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/04/2026. At the time of this survey, Cura of Sauk Centre Nursing Home Building 03 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. Cura of Sauk Centre Nursing Home building 03 is a complete remodel of 27 rooms and is a 2-story building with no basement and is fully fire sprinkler protected. Construction was completed in 2023. Construction type is determined to be Type II (111). This building consists of 3 smoke compartments. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K0000		03/24/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EAST ADDITION B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

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