



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 11, 2026

Administrator
CURA OF SANDSTONE
109 COURT AVENUE SOUTH
SANDSTONE, MN 55072

RE: CCN: 245454

Cycle Start Date: March 5, 2026

Dear Administrator:

On April 21, 2026, we notified you a remedy was imposed. On May 29, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 20, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 5, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 21, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 20, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Re: Reinspection Results
Event ID: 1F3553-H2

Dear Administrator:

On May 29, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 8, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
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E0000	Initial Comments On 4/6/26 to 4/8/26, 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				
F0000	INITIAL COMMENTS On 4/6/26 to 4/8/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54541099C (2749383). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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				
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control		F0880				

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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F0880 SS = F	Continued from page 1 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 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			F0880			

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F0880 SS = F	Continued from page 2 (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, 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 [REDACTED] 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	F0880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0880 SS = F	Continued from page 3 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 ■■■'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 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 ■■■'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 ■■■'s record, confirmed the culture results, and that according to the culture results ■■■ 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	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0880 SS = F	Continued from page 4 of the facility's Infection Control Program. █ █'s annual Minimum Data Set (MDS) dated 3/4/26 indicated █ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated █ was always incontinent of bowel and bladder, and dependent of staff for toileting hygiene. █'s care plan undated, indicated █ 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 █'s room and told █ 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. █'s Pants were lowered, the brief was opened up and confirmed █ was dirty with urine. NA-G removed █'s old dirty brief and washed the front of his peri area with wipes. █ was rolled to the right side and NA-G cleaned the buttock region. Rolled to the right side. Barrier cream was then applied to █'s buttock. With the contaminated gloves still on, NA-G then placed the new brief on █ 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 items and sanitize. Soap and water were to be used for enteric precautions, before/after using the	F0880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0880 SS = F	Continued from page 5 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.	F0880		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] [REDACTED] 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 [REDACTED] reviewed for accident hazards. Finally, the facility failed to evaluate a resident with an increased risk of aspiration for 1 of 1 residents [REDACTED] reviewed for accident hazards. Findings include: [REDACTED] [REDACTED]'s quarterly Minimum Data Set (MDS) dated 2/9/26, identified [REDACTED] had moderate cognition, and diagnoses included cerebral infarct (stroke). [REDACTED] 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. [REDACTED] did not ambulate outside of the bedroom or bathroom. [REDACTED]'s undated Care Plan, identified [REDACTED] had potential for injury related to impaired mobility, impaired cognition. [REDACTED] was impulsive and consistently wouldn't ask for assistance or use the	F0689		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = E	Continued from page 6 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 [REDACTED] had a self-care deficit related to diagnosis of stroke. Interventions included PER THERAPY [REDACTED] may 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 [REDACTED] [REDACTED]'s Therapy Communication dated 2/12/26, identified [REDACTED] 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 [REDACTED] exited the bathroom and were walking towards [REDACTED]'s recliner. DON was walking alongside and not touching [REDACTED]. [REDACTED] was pushing a 4 wheeled walker. [REDACTED] 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 [REDACTED]'s transfer, [REDACTED] used a 4 wheeled walker, although staff had not used a gait belt. The DON stated [REDACTED]'s care plan identified staff were to use a gait belt with [REDACTED] 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. [REDACTED] [REDACTED]'s Significant Change MDS dated 2/18/26 indicated [REDACTED] was significantly cognitively impaired. [REDACTED]'s diagnoses included unspecified dementia, unspecified disorientation, atrial fib, and hypertension. MDS section GG indicated [REDACTED] needs moderate assistance with dressing and minimal assistance with walking. [REDACTED]'s care plan dated 4/8/26, identified:	F0689		

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F0689 SS = E	Continued from page 7 Self-care deficit related to diagnosis of dementia, interventions included: ambulation: 1 staff assist with belt and walker. ■■■ was not safe to ambulate independently. ■■■ dressing: 1 staff assist ■■■ ■■■ 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. ■■■ 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 ■■■ to wear appropriate footwear/shoes. During an observation on 4/8/26 at 7:10 a.m., ■■■ was ambulating in the hallway to a chair in the dining room with nursing assistant (NA)-B. ■■■ 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 ■■■ get dressed and walked with ■■■ to the dining room, and they had not noticed that ■■■ just had socks on their feet. NA-B stated ■■■ should wear shoes when walking, and they were concerned ■■■ could slip if not wearing shoes or non-slip socks. NA-B stated they would apply non-slip footwear to ■■■'s feet immediately. During an interview on 4/8/26 at 11:35 a.m., registered nurse (RN)-C stated ■■■ 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 ■■■'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	F0689		

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F0689 SS = E	Continued from page 8 walking per ■■■'s care plan, they expected staff would ensure ■■■ had shoes or non-slip socks on and used their walker, and that staff remained close to ■■■ and provided verbal cuing. The DON stated concerns for slipping and increased fall risk if ■■■ 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. ■■■ ■■■'s quarterly MDS dated 2/4/26, identified intact cognition and diagnoses of major depressive disorder with psychotic symptoms, bipolar disorder, hallucinations, parkinsonism, insomnia, chronic pain syndrome, and mild cognitive impairment. ■■■'s MDS also indicated delusions, physical and verbal behavior toward others, and wandering behavior. ■■■ was dependent for transfers and was able to propel his own wheelchair with partial assist. ■■■'s care plan included a focus statement dated 3/6/26, indicating ■■■ 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 ■■■'s reach. ■■■'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 ■■■ 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 ■■■'s reach. During an observation 4/6/26 at 3:03 p.m., ■■■ had	F0689		

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F0689 SS = E	Continued from page 9 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 ■■■'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. ■■■ 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 ■■■ 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 ■■■ 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 ■■■ 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 ■■■ having recent suicidal ideations or threats. RN-B confirmed the treatment administration record (TAR) identified to keep all cords out of ■■■'s reach due to suicidal ideation, and to monitor for suicidal ideation. During an observation on 4/6/26 at 7:27 p.m., ■■■ was in his room in a wheelchair, moving about his room and all 11 cords were still in the same places. 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 ■■■'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, ■■■ did have a diagnosis of bipolar disorder, and was followed by in-house psychiatric service. The DON stated she thought ■■■'s mood lately had been good, and after reviewing the EMR stated the last time ■■■ had made suicidal statements was 2/1/26, and they did get an order for him to be evaluated in the emergency room	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = E	Continued from page 10 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 ■ 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., ■ was in his room in a recliner with the footrest up. A trash can with no liner was observed in ■'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 ■ in the recliner. During an interview on 4/7/26 at 1:34 p.m., NA-C stated she knew ■ 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 ■ 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 ■ 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 ■ NA-A stated ■ 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	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = E	Continued from page 11 reach, NA-A stated this was new and she didn't know about this. NA-A stated she wanted to go check ■■■'s room, upon entering NA-A stated there were lots of cords in here, and started to remove the fan and ■■■ 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 ■■■'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 ■■■'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. During an interview on 4/8/26 at 3:28 p.m., RN-C, an assistant director of nursing, stated ■■■ 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 ■■■'s reach, the risk would be ■■■ could get a hold of a cord and hurt himself if he were in that mindset. ■■■ ■■■'s annual MDS dated 2/10/26 indicated ■■■ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated ■■■ was on a mechanically altered diet as a resident. ■■■'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. ■■■'s provider order dated 3/17/25, indicated to discontinue (DC) regular diet with thin liquids and start mechanical soft diet with slightly thickened	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 12 liquids █'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 █'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., █ 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., █ 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., █ 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. On 2/26/26 at 12:52 p.m., █ started coughing with food in his mouth. at the mealtime. █'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 █ had aspirated, but █ was making "bear growling noise",	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 13 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. ■ 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 ■ 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 ■ 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 ■ 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 ■ when the choking occurred on 2/26/26. I was not ■'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 ■'s order history and stated there had never been an order for speech therapy to evaluate swallowing since arrival in the facility.	F0689		

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F0689 SS = E	Continued from page 14 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.			F0689			
	Facility aspiration precautions policy was not received.						
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			F0580			

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F0580 SS = D	Continued from page 15 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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 ■■■ resident reviewed for change of condition. Findings Include: ■■■'s annual Minimum Data Set (MDS) dated 2/10/26 indicated ■■■ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated ■■■ was on a mechanically altered diet ■■■'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. ■■■'s provider orders dated 3/19/25, identified a mechanical soft textured solid food diet with thin liquids. Review of ■■■'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., ■■■ 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., ■■■ started coughing with food in his mouth at the mealtime. ■■■'s face	F0580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0580 SS = D	Continued from page 16 became red and appeared to be having difficulty chewing and swallowing. Attempted to listen to his lung sounds as it had sounded like ■ had aspirated, but ■ 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 ■ 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.	F0580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] reviewed for unnecessary medications. This deficient practice had the potential for resident discomfort and medical complications related to constipation. Findings include: [REDACTED] [REDACTED] s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition, a diagnosis of slow-transit constipation and occasional bowel incontinence. [REDACTED] was dependent for transfers to the toilet and for toilet hygiene. [REDACTED] 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. [REDACTED] s medication administration record (MAR) for March 2026 identified PRN bowel medications and dietary interventions from Standing Orders were utilized 19 times. [REDACTED] s MAR from 4/1 to 4/8/26 identified they were utilized seven times. [REDACTED] s electronic medical record (EMR) from 4/1 to 4/8/26 identified one bowel movement (BM) on 4/5/26.	F0684		

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F0684 SS = D	Continued from page 18 █'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 █ 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 █ and another resident. RN-B stated the bowel protocol started after two days on no BM, but she will talk to the resident, like █ today, he will go three days without intervention and has said it was normal for him to go a couple days without going and █ 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. █ █'s quarterly MDS dated 1/12/26, identified intact cognition, ability to make her needs known and diagnoses of "need medical record". █ was always continent of bowel and independent with toileting hygiene, and a stand-by assist for transfers. █'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. █'s care plan also indicated she needed stand-by assist of one as needed for transfers and walked independently with a walker. █'s provider order dated 12/15/22, identified polyethylene glycol powder 17 grams by mouth every 12 hours PRN for constipation. █'s MAR for March and April 2026, identified the medication wasn't used. █'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.	F0684		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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F0684 SS = D	Continued from page 19 3/11, BM documented 3/13, 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 documented 3/18, 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 bowel protocol for one day. 3/29, prunes, prune juice or BAP one time only for bowel protocol for one day. 3/29, BM recorded 3/31, BM recorded 4/1, BM recorded 4/3, 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 recorded █'s EMR didn't contain evidence of bowel assessments or provider notification for on-going constipation and PRN use.	F0684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0684 SS = D	Continued from page 20 During an interview on 4/6/26 at 1:57 p.m., ■■■ 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 ■■■ today, she had just transferred ■■■ off the bed so she could take her walker and go to the bathroom. ■■■ 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. ■■■ 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	F0684		

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F0684 SS = D	Continued from page 21 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.	F0684		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform a passive range of motion (PROM) program for 1 of 2 [REDACTED] residents reviewed for restorative care. Findings include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/18/26 indicated [REDACTED] was cognitively intact. Diagnoses included multiple sclerosis (MS) and paraplegia. Section GG indicated [REDACTED] had impairment to one upper extremity and both lower extremities. [REDACTED]'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. [REDACTED]'s PROM documentation from 3/10/26 to 4/8/26 were reviewed and indicated the following:	F0688		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0688 SS = D	Continued from page 22 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., [REDACTED] was observed to have contractures to her right upper extremity and both of her lower extremities During an interview on 4/06/26 at 4:23 p.m., [REDACTED] 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 [REDACTED] was on a PROM program that needed to be done daily during the day shift and evening shift. [REDACTED] 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.	F0688		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F0693		

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F0693 SS = D	Continued from page 23 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] residents reviewed for TF Findings Include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/9/26 indicated [REDACTED] had moderate cognitive impairment. Diagnoses included abdominal distention and hemiplegia (complete to total muscle loss to one side of the body). [REDACTED] received TF with 51% or greater intake received through TF. [REDACTED]'s care plan undated, indicated a nutritional problem related to a diagnosis of hemiplegia. Interventions included to provide TF and water flushes as ordered. [REDACTED]'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. [REDACTED]'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., [REDACTED] 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 [REDACTED] was lying flat in bed with the TF running continuously. NA-F stated [REDACTED] needed to have the HOB greater than 30 degrees to prevent aspiration, but [REDACTED] 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 [REDACTED]'s room to attempt to raise the HOB greater than 30 degrees or report findings to the charge	F0693		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0693 SS = D	Continued from page 24 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.	F0693		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: 1 Number of residents cited: 1 Based 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 () reviewed for antibiotic use. Findings include: s annual Minimum Data Set (MDS) dated 3/18/26, indicated was cognitively intact. s diagnoses included multiple sclerosis, dysuria, obesity, diabetes mellitus type 2, paraplegia, and dementia. s care plan dated 3/18/26, identified had	F0881		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0881 SS = D	Continued from page 25 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 [REDACTED]'s urinary color, vaginal discharge, and increasing confusion and agitation. [REDACTED]'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. [REDACTED]'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 [REDACTED]'s symptoms included urinary odor, vaginal discharge, increasing confusion and agitation. [REDACTED]'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. [REDACTED]'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. [REDACTED]'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 [REDACTED]'s medical record reported [REDACTED]'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 [REDACTED] 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 [REDACTED]'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 [REDACTED] had a history	F0881		

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F0881 SS = D	Continued from page 26 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.		F0881				
F0641 SS = A	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 (ii) Causes another individual to certify a material and false statement in a resident assessment is		F0641				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0641 SS = A	Continued from page 27 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 interview and document review, the facility failed to ensure minimum data set (MDS) assessments were accurately coded for 2 of 2 () residents reviewed for MDS. Findings include: () ()'s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition and a diagnosis of diabetes mellitus (DM) with diabetic neuropathy. ()'s provider order dated 7/2/25, identified an order for Ozempic (semaglutide) 4 milligrams (mg) per 3 milliliters (mL), inject 1 mg in the morning every Friday related to DM. During interview on 4/8/26 at 12:12 p.m., registered nurse (RN)-A stated MDS's were completed upon admission, readmission, quarterly, and with significant changes. Ozempic, and other GLP-1 medications, were considered insulin and were coded in the medication section, under the injection and the insulin areas of the MDS. After prompting, RN-A reviewed GLP-1 classification and stated Ozempic was not classified as insulin and should not be coded as insulin on the MDS. () ()'s annual Minimum Data Set (MDS) dated 3/2/26, identified () was cognitively intact, and diagnoses included diabetes. () received insulin and an injection once during the assessment period. ()'s care plan identified () was at risk for hypo/hyperglycemia and staff were to check ()'s blood glucose three times daily before meals. ()'s physician orders identified an order for Ozempic (semaglutide) 2 mg/3 ml injector pen – inject 0.5 mg subcutaneously once weekly for diabetes. During interview on 4/6/26 at 2:26 p.m., () stated staff checked her blood sugar three times daily, received a weekly injection of Ozempic, however did	F0641		

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F0641 SS = A	Continued from page 28 not use insulin. During interview on 4/8/26 at 12:12 p.m., registered nurse (RN)-A stated MDS's were completed upon admission, readmission, quarterly, and with significant changes. Ozempic, and other GLP-1 medications, were considered insulin and were coded in the medication section, under the injection and the insulin areas of the MDS. After prompting, RN-A reviewed GLP-1 classification and stated Ozempic was not classified as insulin and should not be coded as insulin on the MDS. RN-A stated [REDACTED] s Ozempic was coded in error. A facility policy, Minimum Data Set, Management of, Skilled Nursing Facility dated April 2026, identified its purpose was to ensure the facility maintains an accurate and compliant process for completing, submitting, and transmitting MDS assessments in accordance with federal and Minnesota regulations.	F0641		

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 to 4/8/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54541099C (2749383). NO licensing orders were		20000				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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20000	Continued from page 1 issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.			20875			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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20875	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] reviewed for unnecessary medications. This deficient practice had the potential for resident discomfort and medical complications related to constipation. Findings include: [REDACTED] [REDACTED]'s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition, a diagnosis of slow-transit constipation and occasional bowel incontinence. [REDACTED] was dependent for transfers to the toilet and for toilet hygiene. [REDACTED]'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. [REDACTED]'s medication administration record (MAR) for March 2026 identified PRN bowel medications and dietary interventions from Standing Orders were utilized 19 times. [REDACTED]'s MAR from 4/1 to 4/8/26 identified they were utilized seven times. [REDACTED]'s electronic medical record (EMR) from 4/1 to 4/8/26 identified one bowel movement (BM) on 4/5/26. [REDACTED]'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 [REDACTED] 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			20875			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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20875	Continued from page 3 BM list, for example today she had [REDACTED] and another resident. RN-B stated the bowel protocol started after two days on no BM, but she will talk to the resident, like [REDACTED] today, he will go three days without intervention and has said it was normal for him to go a couple days without going and [REDACTED] 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. [REDACTED] [REDACTED]'s quarterly MDS dated 1/12/26, identified intact cognition, ability to make her needs known and diagnoses of "need medical record". [REDACTED] was always continent of bowel and independent with toileting hygiene, and a stand-by assist for transfers. [REDACTED]'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. [REDACTED]'s care plan also indicated she needed stand-by assist of one as needed for transfers and walked independently with a walker. [REDACTED]'s provider order dated 12/15/22, identified polyethylene glycol powder 17 grams by mouth every 12 hours PRN for constipation. [REDACTED]'s MAR for March and April 2026, identified the medication wasn't used. [REDACTED]'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 documented 3/13, 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 documented 3/18, prunes, prune juice or BAP one time only for bowel protocol for one day.	20875			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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20875	Continued from page 4 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 bowel protocol for one day. 3/29, prunes, prune juice or BAP one time only for bowel protocol for one day. 3/29, BM recorded 3/31, BM recorded 4/1, BM recorded 4/3, 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 recorded █'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., █ 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 █ today, she had just transferred █ off the bed so she could take her walker and go to the bathroom. █ would put her light on when she was done. NA-B confirmed she would be responsible for documenting resident BMs.	20875			

Minnesota Department of Health

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20875	Continued from page 5 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. Sara 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for bowel tracking to assure they			20875			

Minnesota Department of Health

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20875	Continued from page 6 are receiving the necessary treatment/services to prevent complications related to constipation. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875			
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform a passive range of motion (PROM) program for 1 of 2 [REDACTED] residents reviewed for restorative care. Findings include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/18/26 indicated [REDACTED] was cognitively intact. Diagnoses included multiple sclerosis (MS) and paraplegia. Section GG indicated [REDACTED] had impairment to one upper extremity and both lower extremities. [REDACTED]'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. [REDACTED]'s PROM documentation from 3/10/26 to 4/8/26 were reviewed and indicated the following:	20895			

Minnesota Department of Health

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20895	Continued from page 7 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., [REDACTED] was observed to have contractures to her right upper extremity and both of her lower extremities During an interview on 4/06/26 at 4:23 p.m., [REDACTED] 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 [REDACTED] was on a PROM program that needed to be done daily during the day shift and evening shift. [REDACTED] 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895			
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and	20930			

Minnesota Department of Health

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20930	Continued from page 8 feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 residents reviewed for TF. Findings Include: resident's annual Minimum Data Set (MDS) dated 3/9/26 indicated resident had moderate cognitive impairment. Diagnoses included abdominal distention and hemiplegia (complete to total muscle loss to one side of the body). resident received TF with 51% or greater intake received through TF. resident's care plan undated, indicated a nutritional problem related to a diagnosis of hemiplegia. Interventions included to provide TF and water flushes as ordered. resident'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. resident'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., resident 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 resident was lying flat in bed with the TF running continuously. NA-F stated resident needed to have the HOB greater than 30 degrees to prevent aspiration, but resident 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 resident's	20930		

Minnesota Department of Health

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20930	Continued from page 9 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.SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20930			
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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			21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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21375	Continued from page 10 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 [REDACTED] 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 [REDACTED]'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	21375			

Minnesota Department of Health

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21375	Continued from page 11 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 ■■■'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 ■■■'s record, confirmed the culture results, and that according to the culture results ■■■ 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. ■■■ ■■■'s annual Minimum Data Set (MDS) dated 3/4/26 indicated ■■■ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated ■■■ was always incontinent of bowel and bladder, and dependent of staff for toileting hygiene. ■■■'s care plan undated, indicated ■■■ 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 ■■■'s room and told ■■■ 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. ■■■'s Pants were lowered, the brief was opened up and confirmed ■■■ was dirty with urine. NA-G removed ■■■'s old dirty brief and washed the front of his peri area with wipes. ■■■ was rolled to the right side and NA-G cleaned the buttock region. Rolled to the right side. Barrier cream was then applied to ■■■'s buttock. With the contaminated gloves still on, NA-G then placed the new brief on			21375			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072		
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21375	Continued from page 12 █ 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 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. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375			
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665			

Minnesota Department of Health

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21665	Continued from page 13 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review 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 reviewed for accident hazards. Findings include: s quarterly Minimum Data Set (MDS) dated 2/4/26, identified intact cognition and diagnoses of major depressive disorder with psychotic symptoms, bipolar disorder, hallucinations, parkinsonism, insomnia, chronic pain syndrome, and mild cognitive impairment. s MDS also indicated delusions, physical and verbal behavior toward others, and wandering behavior. was dependent for transfers and was able to propel his own wheelchair with partial assist. s care plan included a focus statement dated 3/6/26, indicating 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 s reach. 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 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 s reach. During an observation 4/6/26 at 3:03 p.m., 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 s bed on a bedside table, there was a charging strip	21665			

Minnesota Department of Health

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21665	Continued from page 14 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. ■ 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., nursing assistant (NA)-E stated she was familiar with ■ 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 ■ 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 ■ 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., registered nurse (RN)-B stated they didn't know of ■ having recent suicidal ideations or threats. RN-B confirmed the treatment administration record (TAR) identified to keep all cords out of ■'s reach due to suicidal ideation, and to monitor for suicidal ideation. During an observation on 4/6/26 at 7:27 p.m., ■ was in his room in a wheelchair, moving about his room and all 11 cords were still in the same places. 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 ■'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, ■ did have a diagnosis of bipolar disorder, and was followed by in-house psychiatric service. The DON stated she thought ■'s mood lately had been good, and after reviewing the EMR stated the last time ■ 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	21665			

Minnesota Department of Health

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21665	Continued from page 15 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 ■ 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., ■ was in his room in a recliner with the footrest up. A trash can with no liner was observed in ■'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 ■ in the recliner. During an interview on 4/7/26 at 1:34 p.m., NA-C stated she knew ■ 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 ■ 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 ■ 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 ■ NA-A stated ■ 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 ■'s room, upon entering NA-A stated there were lots of cords in here, and started to remove the fan and ■ said, "hey what are you doing?". NA-A stated she was going to check with management	21665			

Minnesota Department of Health

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21665	Continued from page 16 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 ■■■'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 ■■■'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. During an interview on 4/8/26 at 3:28 p.m., RN-C, an assistant director of nursing, stated ■■■ 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 thee 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 director of nursing (DON) stated staff could see the care plan and orders and would have expected they would have taken them out of ■■■'s reach, the risk would be ■■■ could get a hold of a cord and hurt himself if he were in that mindset. SUGGESTED METHOD OF CORRECTION: The DON or designee should ensure staff are educated on policies and procedures to keep residents safe. The DON or designee should identify all residents at risk for harm as a vulnerable adult and update/implement measures to keep each resident safe. In addition, the facility should care plan those measures for each resident involved and/or at risk. The DON or designee should perform measurable audits to ensure all care plans are updated and interventions consistently implemented. Results of those audits should go to the Quality Assurance Performance Improvement (QAPI) for determination of compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665			
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members.	21830			

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21830	Continued from page 17 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.			21830			

Minnesota Department of Health

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21830	Continued from page 18 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] resident reviewed for change of condition. Findings Include: [REDACTED]'s annual Minimum Data Set (MDS) dated 2/10/26 indicated [REDACTED] had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated [REDACTED] was on a mechanically altered diet [REDACTED]'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. [REDACTED]'s provider orders dated 3/19/25, identified a mechanical soft textured solid food diet with thin liquids. Review of [REDACTED]'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., [REDACTED] was eating lunch and	21830			

Minnesota Department of Health

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21830	Continued from page 19 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., ■ started coughing with food in his mouth at the mealtime. ■'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 ■ had aspirated, but ■ 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 ■ 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	21830			

Minnesota Department of Health

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21830	Continued from page 20 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON, or designee, could review applicable policies and procedures and inservice staff on timely notification to resident representatives and/or guardians; then audit resident charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21830			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 21, 2026

Administrator
SANDSTONE HEALTH CARE CENTER
109 COURT AVENUE SOUTH
SANDSTONE, MN 55072

RE: CCN: 245454

Cycle Start Date: March 5, 2026

Dear Administrator:

On March 19, 2026, we informed you that we may impose enforcement remedies.

On April 21, 2026, we informed you of imposed enforcement remedies.

On April 8, 2026, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 5, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 5, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, SANDSTONE HEALTH CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request

for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 21, 2026

Administrator
SANDSTONE HEALTH CARE CENTER
109 COURT AVENUE SOUTH
SANDSTONE, MN 55072

Re: State Nursing Home Licensing Orders

Event ID: 1F3553-H1

Dear Administrator:

The above facility survey was completed on April 8, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An Annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/07/2026. At the time of this survey, Sandstone Health Care Center 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 19 Existing Health Care 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			K0000			04/27/2026

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
(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
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. Sandstone Health Care Center, is a 1-story building with a partial basement. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1988 an addition was constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. Has an attached 2 story Assisted Living. Remodel complete in Spring 2021. The building is fully fire sprinklered protected and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			04/27/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small			K0324	The identified residential cooking device was immediately taken out of service by maintenance staff. The device and associated safety components were inspected to ensure compliance with applicable NFPA standards. Any identified deficiencies were corrected, including cleaning, repair, or replacement of components as necessary. The cooking device was not returned to service until it was verified to be safe and compliant. The facility conducted a comprehensive inspection of all residential cooking devices throughout the building, including but not limited to stoves, ovens, microwave units, and		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
(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
K0324 SS = E Bldg. 01	Continued from page 2 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associated with residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 04/07/2026 at 9:30 AM, it was revealed by observation that the residential stove-range located in the Activity room not equipped with a 120 min max timeout device or mechanism. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Continued from page 2 related safety features. Documentation of inspections was reviewed to ensure all devices meet NFPA requirements for inspection, maintenance, and safe operation. The Maintenance Director or designee will conduct and document monthly inspections of residential cooking devices. Inspection logs will be reviewed quarterly by facility leadership and during the Quality Assurance and Performance Improvement (QAPI) committee meetings. All corrective actions will be completed by May __15th__, 2026.		05/15/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power			K0920	The identified electrical adaptive device(s) were immediately removed from use and inspected by the Maintenance Director or qualified personnel. Any device found to be damaged, improperly used, or not compliant with NFPA 99 requirements was repaired or replaced. Devices were not returned to service. The facility conducted a comprehensive inspection of all electrical adaptive devices throughout the facility, including but not limited to power strips, extension cords, bed adapters, and resident-used electrical equipment. All devices were reviewed for proper usage, condition, and compliance with NFPA 99 requirements. Non-compliant devices were removed from service. Implemented a process requiring staff to report damaged or questionable electrical devices		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
(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
K0920 SS = E Bldg. 01	Continued from page 3 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, sections 400.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/07/2026 at 11:00 AM, it was revealed by observation that an extension cord was being used in Room 328 for a TV. 2. On 04/07/2026 at 11:08 AM, it was revealed by observation that a multi-plug adapter was being used to plug in a refrigerator in room 323. 3. On 04/07/2026 at 11:14 AM, it was revealed by observation that a refrigerator was plugged into a power strip. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0920	Continued from page 3 immediately to maintenance. Established a routine inspection schedule for electrical adaptive devices, with documented findings. The Maintenance Director or designee will conduct and document monthly inspections of electrical adaptive devices. Findings will be reviewed quarterly by facility leadership and reported to the Quality Assurance and Performance Improvement (QAPI) committee. All corrective actions will be completed by May __15th__, 2026.		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072			
(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 4/6/26 to 4/8/26, 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			
F0000	INITIAL COMMENTS On 4/6/26 to 4/8/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54541099C (2749383). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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			
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control			F0880			

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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(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
F0880 SS = F	Continued from page 1 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 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			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072	
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F0880 SS = F	Continued from page 2 (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, 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 [REDACTED] 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	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0880 SS = F	Continued from page 3 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 ■■■■■'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 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 ■■■■■'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 ■■■■■'s record, confirmed the culture results, and that according to the culture results ■■■■■ 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	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0880 SS = F	Continued from page 4 of the facility's Infection Control Program. █ █'s annual Minimum Data Set (MDS) dated 3/4/26 indicated █ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated █ was always incontinent of bowel and bladder, and dependent of staff for toileting hygiene. █'s care plan undated, indicated █ 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 █'s room and told █ 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. █'s Pants were lowered, the brief was opened up and confirmed █ was dirty with urine. NA-G removed █'s old dirty brief and washed the front of his peri area with wipes. █ was rolled to the right side and NA-G cleaned the buttock region. Rolled to the right side. Barrier cream was then applied to █'s buttock. With the contaminated gloves still on, NA-G then placed the new brief on █ 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 items and sanitize. Soap and water were to be used for enteric precautions, before/after using the	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0880 SS = F	Continued from page 5 bathroom, c. diff and before/after eating. To prevent the spread infection.	F0880		
F0689 SS = E	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. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] 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 [REDACTED] reviewed for accident hazards. Finally, the facility failed to evaluate a resident with an increased risk of aspiration for 1 of 1 residents [REDACTED] reviewed for accident hazards. Findings include: [REDACTED] [REDACTED]'s quarterly Minimum Data Set (MDS) dated 2/9/26, identified [REDACTED] had moderate cognition, and diagnoses included cerebral infarct (stroke). [REDACTED] 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. [REDACTED] did not ambulate outside of the bedroom or bathroom. [REDACTED]'s undated Care Plan, identified [REDACTED] had potential for injury related to impaired mobility, impaired cognition. [REDACTED] was impulsive and consistently wouldn't ask for assistance or use the	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 6 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 [REDACTED] had a self-care deficit related to diagnosis of stroke. Interventions included PER THERAPY [REDACTED] mya 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 [REDACTED] [REDACTED]'s Therapy Communication dated 2/12/26, identified [REDACTED] 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 [REDACTED] exited the bathroom and were walking towards [REDACTED]'s recliner. DON was walking alongside and not touching [REDACTED]. [REDACTED] was pushing a 4 wheeled walker. [REDACTED] 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 [REDACTED]'s transfer, [REDACTED] used a 4 wheeled walker, although staff had not used a gait belt. The DON stated [REDACTED]'s care plan identified staff were to use a gait belt with [REDACTED] 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. [REDACTED] [REDACTED]'s Significant Change MDS dated 2/18/26 indicated [REDACTED] was significantly cognitively impaired. [REDACTED]'s diagnoses included unspecified dementia, unspecified disorientation, atrial fib, and hypertension. MDS section GG indicated [REDACTED] needs moderate assistance with dressing and minimal assistance with walking. [REDACTED]'s care plan dated 4/8/26, identified:	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 7 Self-care deficit related to diagnosis of dementia, interventions included: ambulation: 1 staff assist with belt and walker. ■■■ was not safe to ambulate independently. ■■■ ■■■ dressing: 1 staff assist ■■■ ■■■ 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. ■■■ 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 ■■■ to wear appropriate footwear/shoes. During an observation on 4/8/26 at 7:10 a.m., ■■■ was ambulating in the hallway to a chair in the dining room with nursing assistant (NA)-B. ■■■ 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 ■■■ get dressed and walked with ■■■ to the dining room, and they had not noticed that ■■■ just had socks on their feet. NA-B stated ■■■ should wear shoes when walking, and they were concerned ■■■ could slip if not wearing shoes or non-slip socks. NA-B stated they would apply non-slip footwear to ■■■'s feet immediately. During an interview on 4/8/26 at 11:35 a.m., registered nurse (RN)-C stated ■■■ 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 ■■■'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	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 8 walking per [REDACTED]'s care plan, they expected staff would ensure [REDACTED] had shoes or non-slip socks on and used their walker, and that staff remained close to [REDACTED] and provided verbal cuing. The DON stated concerns for slipping and increased fall risk if [REDACTED] 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. [REDACTED] [REDACTED]'s quarterly MDS dated 2/4/26, identified intact cognition and diagnoses of major depressive disorder with psychotic symptoms, bipolar disorder, hallucinations, parkinsonism, insomnia, chronic pain syndrome, and mild cognitive impairment. [REDACTED]'s MDS also indicated delusions, physical and verbal behavior toward others, and wandering behavior. [REDACTED] was dependent for transfers and was able to propel his own wheelchair with partial assist. [REDACTED]'s care plan included a focus statement dated 3/6/26, indicating [REDACTED] 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 [REDACTED]'s reach. [REDACTED]'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 [REDACTED] 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 [REDACTED]'s reach. During an observation 4/6/26 at 3:03 p.m., [REDACTED] had	F0689		

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F0689 SS = E	Continued from page 9 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 ■■■'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. ■■■ 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 ■■■ 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 ■■■ 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 ■■■ 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 ■■■ having recent suicidal ideations or threats. RN-B confirmed the treatment administration record (TAR) identified to keep all cords out of ■■■'s reach due to suicidal ideation, and to monitor for suicidal ideation. During an observation on 4/6/26 at 7:27 p.m., ■■■ was in his room in a wheelchair, moving about his room and all 11 cords were still in the same places. 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 ■■■'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, ■■■ did have a diagnosis of bipolar disorder, and was followed by in-house psychiatric service. The DON stated she thought ■■■'s mood lately had been good, and after reviewing the EMR stated the last time ■■■ had made suicidal statements was 2/1/26, and they did get an order for him to be evaluated in the emergency room	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 10 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 ■ 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., ■ was in his room in a recliner with the footrest up. A trash can with no liner was observed in ■'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 ■ in the recliner. During an interview on 4/7/26 at 1:34 p.m., NA-C stated she knew ■ 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 ■ 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 ■ 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 ■ NA-A stated ■ 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	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = E	Continued from page 11 reach, NA-A stated this was new and she didn't know about this. NA-A stated she wanted to go check ■■■'s room, upon entering NA-A stated there were lots of cords in here, and started to remove the fan and ■■■ 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 ■■■'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 ■■■'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. During an interview on 4/8/26 at 3:28 p.m., RN-C, an assistant director of nursing, stated ■■■ 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 ■■■'s reach, the risk would be ■■■ could get a hold of a cord and hurt himself if he were in that mindset. ■■■ ■■■'s annual MDS dated 2/10/26 indicated ■■■ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated ■■■ was on a mechanically altered diet as a resident. ■■■'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. ■■■'s provider order dated 3/17/25, indicated to discontinue (DC) regular diet with thin liquids and start mechanical soft diet with slightly thickened	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 12 liquids █'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 █'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., █ 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., █ 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., █ 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. On 2/26/26 at 12:52 p.m., █ started coughing with food in his mouth. at the mealtime. █'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 █ had aspirated, but █ was making "bear growling noise",	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0689 SS = E	Continued from page 13 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. ■ 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 ■ 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 ■ 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 ■ 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 ■ when the choking occurred on 2/26/26. I was not ■'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 ■'s order history and stated there had never been an order for speech therapy to evaluate swallowing since arrival in the facility.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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F0689 SS = E	Continued from page 14 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.			F0689			
	Facility aspiration precautions policy was not received.						
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			F0580			

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F0580 SS = D	Continued from page 15 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] resident reviewed for change of condition. Findings Include: [REDACTED]'s annual Minimum Data Set (MDS) dated 2/10/26 indicated [REDACTED] had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated [REDACTED] was on a mechanically altered diet [REDACTED]'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. [REDACTED]'s provider orders dated 3/19/25, identified a mechanical soft textured solid food diet with thin liquids. Review of [REDACTED]'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., [REDACTED] 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., [REDACTED] started coughing with food in his mouth at the mealtime. [REDACTED]'s face	F0580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0580 SS = D	Continued from page 16 became red and appeared to be having difficulty chewing and swallowing. Attempted to listen to his lung sounds as it had sounded like ■ had aspirated, but ■ 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 ■ 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.	F0580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] reviewed for unnecessary medications. This deficient practice had the potential for resident discomfort and medical complications related to constipation. Findings include: [REDACTED] [REDACTED] s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition, a diagnosis of slow-transit constipation and occasional bowel incontinence. [REDACTED] was dependent for transfers to the toilet and for toilet hygiene. [REDACTED] 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. [REDACTED] s medication administration record (MAR) for March 2026 identified PRN bowel medications and dietary interventions from Standing Orders were utilized 19 times. [REDACTED] s MAR from 4/1 to 4/8/26 identified they were utilized seven times. [REDACTED] s electronic medical record (EMR) from 4/1 to 4/8/26 identified one bowel movement (BM) on 4/5/26.	F0684		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0684 SS = D	Continued from page 18 █'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 █ 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 █ and another resident. RN-B stated the bowel protocol started after two days on no BM, but she will talk to the resident, like █ today, he will go three days without intervention and has said it was normal for him to go a couple days without going and █ 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. █ █'s quarterly MDS dated 1/12/26, identified intact cognition, ability to make her needs known and diagnoses of "need medical record". █ was always continent of bowel and independent with toileting hygiene, and a stand-by assist for transfers. █'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. █'s care plan also indicated she needed stand-by assist of one as needed for transfers and walked independently with a walker. █'s provider order dated 12/15/22, identified polyethylene glycol powder 17 grams by mouth every 12 hours PRN for constipation. █'s MAR for March and April 2026, identified the medication wasn't used. █'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.	F0684		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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F0684 SS = D	Continued from page 19 3/11, BM documented 3/13, 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 documented 3/18, 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 bowel protocol for one day. 3/29, prunes, prune juice or BAP one time only for bowel protocol for one day. 3/29, BM recorded 3/31, BM recorded 4/1, BM recorded 4/3, 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 recorded █'s EMR didn't contain evidence of bowel assessments or provider notification for on-going constipation and PRN use.	F0684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0684 SS = D	Continued from page 20 During an interview on 4/6/26 at 1:57 p.m., ■■■ 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 ■■■ today, she had just transferred ■■■ off the bed so she could take her walker and go to the bathroom. ■■■ 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. ■■■ 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	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072	
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F0684 SS = D	Continued from page 21 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.	F0684		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform a passive range of motion (PROM) program for 1 of 2 [REDACTED] residents reviewed for restorative care. Findings include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/18/26 indicated [REDACTED] was cognitively intact. Diagnoses included multiple sclerosis (MS) and paraplegia. Section GG indicated [REDACTED] had impairment to one upper extremity and both lower extremities. [REDACTED]'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. [REDACTED]'s PROM documentation from 3/10/26 to 4/8/26 were reviewed and indicated the following:	F0688		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0688 SS = D	Continued from page 22 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., [REDACTED] was observed to have contractures to her right upper extremity and both of her lower extremities During an interview on 4/06/26 at 4:23 p.m., [REDACTED] 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 [REDACTED] was on a PROM program that needed to be done daily during the day shift and evening shift. [REDACTED] 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.	F0688		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER CURA OF SANDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072	
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F0693 SS = D	Continued from page 23 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] residents reviewed for TF Findings Include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/9/26 indicated [REDACTED] had moderate cognitive impairment. Diagnoses included abdominal distention and hemiplegia (complete to total muscle loss to one side of the body). [REDACTED] received TF with 51% or greater intake received through TF. [REDACTED]'s care plan undated, indicated a nutritional problem related to a diagnosis of hemiplegia. Interventions included to provide TF and water flushes as ordered. [REDACTED]'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. [REDACTED]'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., [REDACTED] 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 [REDACTED] was lying flat in bed with the TF running continuously. NA-F stated [REDACTED] needed to have the HOB greater than 30 degrees to prevent aspiration, but [REDACTED] 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 [REDACTED]'s room to attempt to raise the HOB greater than 30 degrees or report findings to the charge	F0693		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0693 SS = D	Continued from page 24 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.	F0693		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: 1 Number of residents cited: 1 Based 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 () reviewed for antibiotic use. Findings include: 's annual Minimum Data Set (MDS) dated 3/18/26, indicated () was cognitively intact. ()'s diagnoses included multiple sclerosis, dysuria, obesity, diabetes mellitus type 2, paraplegia, and dementia. 's care plan dated 3/18/26, identified () had	F0881		

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F0881 SS = D	Continued from page 25 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 ■■■■■'s urinary color, vaginal discharge, and increasing confusion and agitation. ■■■■■'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. ■■■■■'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 ■■■■■'s symptoms included urinary odor, vaginal discharge, increasing confusion and agitation. ■■■■■'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. ■■■■■'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. ■■■■■'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 ■■■■■'s medical record reported ■■■■■'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 ■■■■■ 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 ■■■■■'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 ■■■■■ had a history	F0881		

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F0881 SS = D	Continued from page 26 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.			F0881			
F0641 SS = A	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 (ii) Causes another individual to certify a material and false statement in a resident assessment is			F0641			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0641 SS = A	Continued from page 27 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 interview and document review, the facility failed to ensure minimum data set (MDS) assessments were accurately coded for 2 of 2 () residents reviewed for MDS. Findings include: () ()'s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition and a diagnosis of diabetes mellitus (DM) with diabetic neuropathy. ()'s provider order dated 7/2/25, identified an order for Ozempic (semaglutide) 4 milligrams (mg) per 3 milliliters (mL), inject 1 mg in the morning every Friday related to DM. During interview on 4/8/26 at 12:12 p.m., registered nurse (RN)-A stated MDS's were completed upon admission, readmission, quarterly, and with significant changes. Ozempic, and other GLP-1 medications, were considered insulin and were coded in the medication section, under the injection and the insulin areas of the MDS. After prompting, RN-A reviewed GLP-1 classification and stated Ozempic was not classified as insulin and should not be coded as insulin on the MDS. () ()'s annual Minimum Data Set (MDS) dated 3/2/26, identified () was cognitively intact, and diagnoses included diabetes. () received insulin and an injection once during the assessment period. ()'s care plan identified () was at risk for hypo/hyperglycemia and staff were to check ()'s blood glucose three times daily before meals. ()'s physician orders identified an order for Ozempic (semaglutide) 2 mg/3 ml injector pen – inject 0.5 mg subcutaneously once weekly for diabetes. During interview on 4/6/26 at 2:26 p.m., () stated staff checked her blood sugar three times daily, received a weekly injection of Ozempic, however did	F0641		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0641 SS = A	Continued from page 28 not use insulin. During interview on 4/8/26 at 12:12 p.m., registered nurse (RN)-A stated MDS's were completed upon admission, readmission, quarterly, and with significant changes. Ozempic, and other GLP-1 medications, were considered insulin and were coded in the medication section, under the injection and the insulin areas of the MDS. After prompting, RN-A reviewed GLP-1 classification and stated Ozempic was not classified as insulin and should not be coded as insulin on the MDS. RN-A stated [REDACTED] s Ozempic was coded in error. A facility policy, Minimum Data Set, Management of, Skilled Nursing Facility dated April 2026, identified its purpose was to ensure the facility maintains an accurate and compliant process for completing, submitting, and transmitting MDS assessments in accordance with federal and Minnesota regulations.	F0641		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 to 4/8/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54541099C (2749383). NO licensing orders were			20000			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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20000	Continued from page 1 issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.			20875			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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20875	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] reviewed for unnecessary medications. This deficient practice had the potential for resident discomfort and medical complications related to constipation. Findings include: [REDACTED] [REDACTED]'s quarterly minimum data set (MDS) dated 2/4/26, identified intact cognition, a diagnosis of slow-transit constipation and occasional bowel incontinence. [REDACTED] was dependent for transfers to the toilet and for toilet hygiene. [REDACTED]'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. [REDACTED]'s medication administration record (MAR) for March 2026 identified PRN bowel medications and dietary interventions from Standing Orders were utilized 19 times. [REDACTED]'s MAR from 4/1 to 4/8/26 identified they were utilized seven times. [REDACTED]'s electronic medical record (EMR) from 4/1 to 4/8/26 identified one bowel movement (BM) on 4/5/26. [REDACTED]'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 [REDACTED] 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	20875			

Minnesota Department of Health

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20875	Continued from page 3 BM list, for example today she had [REDACTED] and another resident. RN-B stated the bowel protocol started after two days on no BM, but she will talk to the resident, like [REDACTED] today, he will go three days without intervention and has said it was normal for him to go a couple days without going and [REDACTED] 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. [REDACTED] [REDACTED]'s quarterly MDS dated 1/12/26, identified intact cognition, ability to make her needs known and diagnoses of "need medical record". [REDACTED] was always continent of bowel and independent with toileting hygiene, and a stand-by assist for transfers. [REDACTED]'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. [REDACTED]'s care plan also indicated she needed stand-by assist of one as needed for transfers and walked independently with a walker. [REDACTED]'s provider order dated 12/15/22, identified polyethylene glycol powder 17 grams by mouth every 12 hours PRN for constipation. [REDACTED]'s MAR for March and April 2026, identified the medication wasn't used. [REDACTED]'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 documented 3/13, 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 documented 3/18, prunes, prune juice or BAP one time only for bowel protocol for one day.	20875			

Minnesota Department of Health

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20875	Continued from page 4 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 bowel protocol for one day. 3/29, prunes, prune juice or BAP one time only for bowel protocol for one day. 3/29, BM recorded 3/31, BM recorded 4/1, BM recorded 4/3, 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 recorded █'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., █ 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 █ today, she had just transferred █ off the bed so she could take her walker and go to the bathroom. █ would put her light on when she was done. NA-B confirmed she would be responsible for documenting resident BMs.	20875			

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20875	Continued from page 5 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. Sara 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for bowel tracking to assure they			20875			

Minnesota Department of Health

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20875	Continued from page 6 are receiving the necessary treatment/services to prevent complications related to constipation. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875			
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform a passive range of motion (PROM) program for 1 of 2 [REDACTED] residents reviewed for restorative care. Findings include: [REDACTED]'s annual Minimum Data Set (MDS) dated 3/18/26 indicated [REDACTED] was cognitively intact. Diagnoses included multiple sclerosis (MS) and paraplegia. Section GG indicated [REDACTED] had impairment to one upper extremity and both lower extremities. [REDACTED]'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. [REDACTED]'s PROM documentation from 3/10/26 to 4/8/26 were reviewed and indicated the following:	20895			

Minnesota Department of Health

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20895	Continued from page 7 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., [REDACTED] was observed to have contractures to her right upper extremity and both of her lower extremities During an interview on 4/06/26 at 4:23 p.m., [REDACTED] 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 [REDACTED] was on a PROM program that needed to be done daily during the day shift and evening shift. [REDACTED] 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and	20930		

Minnesota Department of Health

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20930	Continued from page 8 feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 residents reviewed for TF. Findings Include: s annual Minimum Data Set (MDS) dated 3/9/26 indicated had moderate cognitive impairment. Diagnoses included abdominal distention and hemiplegia (complete to total muscle loss to one side of the body). received TF with 51% or greater intake received through TF. s care plan undated, indicated a nutritional problem related to a diagnosis of hemiplegia. Interventions included to provide TF and water flushes as ordered. 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. 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., 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 was lying flat in bed with the TF running continuously. NA-F stated needed to have the HOB greater than 30 degrees to prevent aspiration, but 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 s	20930		

Minnesota Department of Health

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20930	Continued from page 9 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.SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20930			
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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			21375			

Minnesota Department of Health

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21375	Continued from page 10 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 [REDACTED] 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 [REDACTED]'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	21375			

Minnesota Department of Health

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21375	Continued from page 11 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 ■■■'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 ■■■'s record, confirmed the culture results, and that according to the culture results ■■■ 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. ■■■ ■■■'s annual Minimum Data Set (MDS) dated 3/4/26 indicated ■■■ had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated ■■■ was always incontinent of bowel and bladder, and dependent of staff for toileting hygiene. ■■■'s care plan undated, indicated ■■■ 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 ■■■'s room and told ■■■ 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. ■■■'s Pants were lowered, the brief was opened up and confirmed ■■■ was dirty with urine. NA-G removed ■■■'s old dirty brief and washed the front of his peri area with wipes. ■■■ was rolled to the right side and NA-G cleaned the buttock region. Rolled to the right side. Barrier cream was then applied to ■■■'s buttock. With the contaminated gloves still on, NA-G then placed the new brief on	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
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21375	Continued from page 12 █ 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 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. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21375			
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.			21665			

Minnesota Department of Health

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21665	Continued from page 13 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review 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 reviewed for accident hazards. Findings include: s quarterly Minimum Data Set (MDS) dated 2/4/26, identified intact cognition and diagnoses of major depressive disorder with psychotic symptoms, bipolar disorder, hallucinations, parkinsonism, insomnia, chronic pain syndrome, and mild cognitive impairment. s MDS also indicated delusions, physical and verbal behavior toward others, and wandering behavior. was dependent for transfers and was able to propel his own wheelchair with partial assist. s care plan included a focus statement dated 3/6/26, indicating 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 s reach. 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 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 s reach. During an observation 4/6/26 at 3:03 p.m., 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 s bed on a bedside table, there was a charging strip	21665			

Minnesota Department of Health

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21665	Continued from page 14 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. ■ 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., nursing assistant (NA)-E stated she was familiar with ■ 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 ■ 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 ■ 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., registered nurse (RN)-B stated they didn't know of ■ having recent suicidal ideations or threats. RN-B confirmed the treatment administration record (TAR) identified to keep all cords out of ■'s reach due to suicidal ideation, and to monitor for suicidal ideation. During an observation on 4/6/26 at 7:27 p.m., ■ was in his room in a wheelchair, moving about his room and all 11 cords were still in the same places. 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 ■'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, ■ did have a diagnosis of bipolar disorder, and was followed by in-house psychiatric service. The DON stated she thought ■'s mood lately had been good, and after reviewing the EMR stated the last time ■ 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			21665			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026	
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21665	Continued from page 15 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 ■ 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., ■ was in his room in a recliner with the footrest up. A trash can with no liner was observed in ■'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 ■ in the recliner. During an interview on 4/7/26 at 1:34 p.m., NA-C stated she knew ■ 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 ■ 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 ■ 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 ■ NA-A stated ■ 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 ■'s room, upon entering NA-A stated there were lots of cords in here, and started to remove the fan and ■ said, "hey what are you doing?". NA-A stated she was going to check with management	21665			

Minnesota Department of Health

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21665	Continued from page 16 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 ■■■'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 ■■■'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. During an interview on 4/8/26 at 3:28 p.m., RN-C, an assistant director of nursing, stated ■■■ 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 thee 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 director of nursing (DON) stated staff could see the care plan and orders and would have expected they would have taken them out of ■■■'s reach, the risk would be ■■■ could get a hold of a cord and hurt himself if he were in that mindset. SUGGESTED METHOD OF CORRECTION: The DON or designee should ensure staff are educated on policies and procedures to keep residents safe. The DON or designee should identify all residents at risk for harm as a vulnerable adult and update/implement measures to keep each resident safe. In addition, the facility should care plan those measures for each resident involved and/or at risk. The DON or designee should perform measurable audits to ensure all care plans are updated and interventions consistently implemented. Results of those audits should go to the Quality Assurance Performance Improvement (QAPI) for determination of compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665			
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members.	21830			

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21830	Continued from page 17 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.			21830			

Minnesota Department of Health

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21830	Continued from page 18 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 [REDACTED] resident reviewed for change of condition. Findings Include: [REDACTED]'s annual Minimum Data Set (MDS) dated 2/10/26 indicated [REDACTED] had moderate cognitive impairment. Diagnoses included dementia and epilepsy. The MDS indicated [REDACTED] was on a mechanically altered diet [REDACTED]'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. [REDACTED]'s provider orders dated 3/19/25, identified a mechanical soft textured solid food diet with thin liquids. Review of [REDACTED]'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., [REDACTED] was eating lunch and			21830			

Minnesota Department of Health

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21830	Continued from page 19 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., ■ started coughing with food in his mouth at the mealtime. ■'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 ■ had aspirated, but ■ 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 ■ 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	21830			

Minnesota Department of Health

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21830	Continued from page 20 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON, or designee, could review applicable policies and procedures and inservice staff on timely notification to resident representatives and/or guardians; then audit resident charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21830			