DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 30, 2025

Administrator
Cura Of Sauk Centre
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: April 10, 2025

Dear Administrator:

On May 19, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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May 30, 2025

Administrator
Cura of Sauk Centre
425 N Elm Street
Sauk Centre, MN 56378

Re: Reinspection Results
Event ID: LIVS12

Dear Administrator:

On May 19, 2025 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 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 29, 2025

Administrator
Cura of Sauk Centre
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 14, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 14, 2025.

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 May 14, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cura Of Sauk Centre will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 14, 2025. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 10, 2025 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:

Steven.Delich@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 Steven.Delich@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
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF SAUK CENTRE	425 N ELM STREET SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/7/25 throught 4/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 through 4/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53412402C (MN00111124) and H53412382C (MN00108615). The following complaint was reviewed: H53412384C (MN00111714) with a deficiency cited at F760. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		5/14/25

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F 656	Continued From page 2 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R6) reviewed for urinary tract infections (UTI). Findings include: R6's significant change Minimum Data Set (MDS) dated 1/31/25, identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R6's diagnoses included hypertension, renal insufficiency, thyroid disorder, arthritis, non-Alzheimer's dementia, depression, respiratory failure, chronic respiratory failure with hypoxia, mononeuritis multiplex, morbid obesity and dependence on supplemental oxygen. R6's face sheet, print date of 4/9/25, included a diagnosis of urinary tract infection (UTI). R6's electronic health record indicated the	F 656	R6s careplan was updated on 4/10/25 to reflect R6s history of urinary tract infections with atypical symptoms including increase confusion and agitation, currently taking diuretic, opioid, cathartic medications. An audit will be completed of all residents with history of urinary tract infection. All residents that have recurrent urinary tract infections care plan will reflect their personal history of urinary tract infections. Infection preventionist during interdisciplinary team meetings will review residents identified with recurrent infections and ensure Careplan is updated appropriately.	

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F 656	Continued From page 3 following UTI history: 10/30/24 - was diagnosed with a UTI and was started on Cephalexin (antibiotic) 500 mg every 12 hours for seven days. 11/15/24 - was diagnosed with a UTI and was started on Bactrim (antibiotic) 800-160 mg twice daily for ten days. 12/10/24 - was started on methanamine hippirate (antibacterial medication)- one gram twice daily for recurrent UTI's. 1/9/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days 2/11/25 - was started on a cranberry supplement 500 mg twice daily for recurrent UTI's 3/20/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days. R6's physician orders, print date of 4/9/25, indicated an order for methenamine Hippurate (antibacterial medication used primarily to prevent and treat urinary tract infections) - one gram by mouth twice daily for recurrent UTI's. R6's care plan, print date of 4/9/25, did not include R6's urinary tract infection, R6's history of urinary tract infections, goals of treatment, and interventions allowing the nurse to assess the intervention's outcome and potentially revise care based on the resident's status. During interview on 4/10/25 at 9:58 a.m., registered nurse (RN)-A clinical coordinator stated the clinical coordinators are responsible for updating the resident's care plans. RN-A stated if a resident had an history of UTI's it should be included in the care plan so staff are watching for signs and symptoms and could recognize them	F 656	Reeducation was provided to Clinical Coordinators, MDS Coordinator,Infection Preventionist whom are involved in the direct development of resident care plans on the need to assure that infections and recurrent infections are added to resident care plans. Additionally a new infection checklist will be implemented that will include a reminder to initate a careplan for infection at the time of occurence, a reminder for infection preventionist to assure careplan reflects recurrent infections and appropriate monitoring and interventions. Current CarePlan's, Comprehensive Person-Centered Policy will be reviewed, and revisions will be made as needed. The Director or Nursing and/or designee will conduct audits of resident care plans to assure infections are care planned. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

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F 656	Continued From page 4 earlier to treat the UTI sooner. RN-A stated it was important to include history of UTI's on the care plan to help with implementation of interventions or staff being aware so symptoms could be recognized and acted on. RN-A confirmed R6's care plan did not include that R6 had a history of UTI's or goals/interventions to prevent and treat UTI's. During interview on 4/10/25 at 10:06 a.m., director of nursing (DON) stated each discipline of practice completes their section on the resident's care plan. DON stated medical or nursing related issues were completed by the clinical coordinators. DON stated she would expect staff to update the RN clinical coordinator with any changes with the resident. DON stated if a resident had a history of UTI's, she would expect that to be included in their care plan. DON stated it was important so staff can know that R6 is susceptible to UTI's and that all steps are taken such as, thorough cares, increasing fluids and noticing the symptoms that R6 displays with UTI's so we can respond quickly with treatment. The facility Care Plans, Comprehensive Person-Centered policy, dated 2/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practical able physical, mental, and psychosocial well-being.	F 656		

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F 656	Continued From page 5 c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. d. Incorporate identified problem area. e. Incorporate risk factors associated with identified problems f. Reflect the resident's expressed wishes regarding care and treatment goals. g. Reflect treatment goals, timetable and objectives in measurable outcomes. h. Identify the professional services that are responsible for each element of care: i. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. j. Reflect currently recognized standards of practice for problem areas and conditions. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.	F 656		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		5/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 732	Continued From page 6 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure the required nurse staffing information was posted daily for 3 of 3 days reviewed. This had the potential to affect all 48 residents residing in the facility, visitors and staff who may wish to view the information. Findings include: During observation on 4/7/25 at 11:32 a.m., the nurse staffing information was posted on wall	F 732	The facility immediately corrected the staffing postings to include the facility name, accurate current date, correct staffing titles, and current resident census, and removed any inaccurately labeled information such as TMAs listed under LPNs. This alleged deficient practice has the potential to impact all residents, families, and visitors in the facility, as the required staffing data was not accurately or clearly	

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F 732	Continued From page 7 inside the entrance of the facility. However, the posted nurse staffing information was dated for 4/7/25 and 4/8/25. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted on specific units of the facility labeled "Team Leader LPN [licensed practical nurse] Majestic Oaks" and "Charge Team Lead LPN Whispering Pines" During observation on 4/8/25 at 8:00 a.m., same nurse staffing information remained posted on wall from 4/7/25. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted under the section labeled "Team Leader LPN Majestic Oaks" and "Charge Team Lead LPN Whispering Pines" During observation on 4/9/25 at 8:15 a.m., the nurse staffing information dated for 4/9/25 and 4/10/25 was posted. Posting did not include the facility name, current census and had inaccurate information posted. Posting included trained medication aides (TMA)'s posted under the section labeled "Team Leader LPN Majestic Oaks" and "Charge Team Lead LPN Whispering Pines" During interview on 4/10/25 at 8:52 a.m., business office manager (BOM) confirmed she completed the daily staff postings and posts them to let staff know where they are working and she tried to keep it updated as much as possible. BOM stated she posts two days at a time. BOM confirmed there were TMA's listed under the "Team leader LPN" section, the facility name was not included on posting and the current census	F 732	posted for public access. The Business Office Manager and designees responsible for daily staffing postings were re-educated by the Director of Nursing on federal requirements for nurse staffing postings, including correct formatting, content, and posting times, with emphasis on adhering to the current facility policy. The night shift nurse in Whispering Pines will take out the old staff posting and replace it with the current day. This nurse will be the person responsible for updating the sheets on weekends or after hours. To train our nurses on this process, we sent an email to all nurses, discussed it at our all-staff meeting, and completed an in-person education about it with our nurses. The current staff posting policy will be reviewed and revisions will be made as needed. The Administrator and/or the Business Office Manager will audit the nurse staffing posting for accuracy, completeness, and visibility 5 days per week for 4 weeks, then weekly for 8 weeks with results reported to the QAPI committee. All corrective actions were completed on 4/10/25.	

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	245341	A. BUILDING _____ B. WING _____	C 04/10/2025

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F 732	Continued From page 8 was not reflected on posting. BOM stated it was important to have the correct information so families and resident know the numbers of staffing the facility was running with, ensures we had the correct number of staff on so if something happened, we would have proof that we were properly staffed. BOM stated it was important to have staff listed under the correct titles because it could be false information and give off the wrong information as there are many things an LPN could do that a TMA could not legally do. During interview on 4/10/25 at 10:11 a.m., director of nursing (DON) stated the daily staff posting was for compliance. DON stated TMA's should not be listed under the LPN section as that was false documentation and families could think the TMA was able to do things that an LPN should do. DON confirmed posting did not contain the facility name or the current census. The facility's Posting of Nursing Hours policy, dated 4/25, indicated the facility posted nursing staffing data was to make staffing information readily available for resident and visitors at any given time. Staffing personnel and/or their designee will post the following daily information in a prominent area of the facility: 1. Facility name 2. Current date 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		5/14/25

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F 758	Continued From page 9 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 10 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication regimens were free of unnecessary psychotropic drugs for 3 of 6 (R20, R43 and R6) residents reviewed who had orders for antianxiety medications beyond 14 days without documented rational. Findings include: R20's significant change Minimum Data Set dated 2/26/25, identified severely impaired cognition with diagnosis of Alzheimer's dementia. R20's order listing report dated 4/10/25, identified an order for prn (per requested need) for Ativan (an antianxiety medication) oral tablet 0.5 mg (milligrams) to be given by mouth every 4 hours as needed for terminal agitation with a start date of 2/28/25 and an end date of 2/21/26. R20's care plan dated 2/5/25, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety medication and directed staff to ensure minimum effective therapeutic dosing. R20's February 2025 medication administration record (MAR) indicated she had not used prn Ativan.	F 758	R20, R43 and R6 providers were contacted and clinical rationales were obtained for as needed antianxiety medications beyond 14 days. An audit was completed to assure that all residents with as needed antianxiety medications had a clinical rational for extending beyond 14 days of use. A new assessment was built and implemented within the facilitys electronic health record. All residents that receive as needed psychotropic medications beyond 14 days will have reviewed by nursing and provider to identify an appropriate clinical rationale and appropriate end date for use. This new assessment was completed for all affected residents. Reeducation was completed with Clinical Coordinators, MDS coordinator on the requirement for as needed end dates and clinical rationale, the new assessment in the electronic health record.	

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F 758	Continued From page 11 R20's March 2025 MAR indicated she had used prn Ativan one time. R20's April 2025 MAR indicated she had not used prn Ativan. When reviewed on 4/10/25, R20's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. R43's quarterly MDS dated 2/28/25, identified intact cognition and a diagnosis of anxiety. R43's order listing report dated 4/10/25, identified an order for prn Ativan oral tablet 0.5 mg by mouth one time a day for anxiety and give 0.5 mg by mouth as needed for anxiety with a start date of 4/7/25 and an end date of 10/3/2025. R43's care plan dated 8/27/24, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety and directed staff to ensure minimum effective therapeutic dosing. R43's April 2025 MAR indicated she had used prn Ativan two times. When reviewed on 4/10/25, R43's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. R6's significant change Minimum Data Set dated, 1/31/25 identified severely impaired cognition, diagnoses of Alzheimer's dementia. R6's order listing report dated 4/9/25, identified an order for prn (per requested need) for Ativan (an antianxiety medication) oral tablet 0.5 mg (milligrams) to be given by mouth every 4 hours as needed for terminal agitation with a start date	F 758	Current Psychotropic Medication Management- Long Term Care Policy will be reviewed and revisions to be made as needed. The Director or Nursing and/or designee will conduct audits of as needed psychotropics to assure appropriate end dates and clinical rationales are present. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

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F 758	Continued From page 12 of 2/13/25 and an end date of 1/12/26. R6's care plan print date of 4/9/25, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety medication and directed staff to ensure minimum effective therapeutic dosing. R6's February medication administration record (MAR) indicated she had not used any prn Ativan. R6's March 2025 MAR indicated she had not used any prn Ativan. R6's April 2025 MAR indicated she had not used any prn Ativan. When reviewed on 4/10/25, R6's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. When interviewed on 4/9/25 at 4:47 p.m., the pharmacy consultant (Pharm D) stated a review of resident medications was completed monthly including any psychotropic (drugs that affect thoughts, behaviors, mood and perception) medications. The Pharm D stated any prn psychotropic medication including antianxiety medications such as Ativan were to be ordered only for a 14-day period and any continuation beyond that timeframe required review by and a statement of clinical rationale by the resident's provider. The Pharm D confirmed there was no documented clinical rationale for the extended prn Ativan orders for R20, R43 and R6 and she should have made this recommendation to their providers. When interviewed on 4/10/25 at 9:29 a.m., the director of nursing (DON) stated the facility process for review of psychotropic medications	F 758		

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F 758	Continued From page 13 was done by the facility interdisciplinary team (IDT) monthly. The DON stated her expectation for R20's, R43's and R6 prn antianxiety medication orders would have been to have had a 14-day end date or review and provider clinical rationale for continued use and acknowledged this had been missed for R20, R43 and R6. The facility policy Psychotropic Medication Management-Long Term Care dated 10/2023, identified "As needed orders for psychotropic drugs (with the exception of anti-psychotics) are limited to 14 days. Unless, the attending physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days in which case he/she should document their rationale in the resident's medical record and indicate the duration for the as needed order.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 1 resident (R35) reviewed for medication errors. This failure resulted in actual harm for R35 when she had a fall, sustaining a minor head injury, developed tachycardia (abnormally fast heart rate) and became hypertensive (abnormally high blood pressure) which required ongoing monitoring in the emergency department (ED). The facility had implemented appropriate	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 14 corrective action prior to the onsite investigation, therefore the deficiency is being cited at past non-compliance. Findings include: R35's quarterly Minimum Data Set (MDS) dated 2/14/25, identified R35 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R35's diagnoses included non-traumatic brain dysfunction, hypertension, diabetes mellitus, non-Alzheimer's Dementia, anxiety disorder, nocturia, and generalized edema. A facility report to the State Agency (SA) on 3/24/25, indicated on 3/24/25 at 7:45 a.m., R35 received another resident's medications, and had been sent to the hospital. On 3/24/25 at 8:30 a.m., a progress note indicated R35 had an unwitnessed fall at 8:15 a.m., where R35 obtained a laceration above her left eyebrow. R35 was sent to the emergency room (ER) for further evaluation based on recent received medication that was intended for another resident. On 3/24/25 at 8:45 a.m., a progress note indicated R35 was administered wrong medications. Order written for evaluation and treatment at the ER. R35's Blood Pressure and Pulse Summary dated 4/8/25 indicated on 3/24/25, R35 had a blood pressure (BP) of 179/123, and heart rate (HR) was 129 at 8:05 a.m. At 8:15 a.m. R35's BP was 169/105 and HR was 114 beats per minute (bpm). Normal blood pressure is 120/80 and	F 760		

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F 760	Continued From page 15 normal pulse is 60-100 bpm. R35's Emergency Department Note dated 3/24/25, indicated R35 was given the following medications the morning of 3/24/25: acetaminophen 650 milligrams (mg) - two tabs, aspirin (blood thinner) 81 mg , calcium 600+vitamin D 600-400 mg, citalopram hydrobromide 20 mg (selective serotonin reuptake inhibitor), lisinopril 40 mg (blood pressure medication), metoprolol succinate ER 200 mg (blood pressure medication), omeprazole 20 mg (heartburn medication), primidone 250 mg (seizure medication), torsemide 20 mg (diuretic), and vitamin D 1000 units. R35's hospital History and Physical Summary dated 3/24/25, indicated R35 was accidentally given the wrong medications on the morning of 3/24/25. R35 had the following symptoms: weakness and hypertension. Computed tomography (imaging test that detects injuries) of head was performed with no abnormalities noted. Per note, pharmacy was updated and advised the metoprolol would peak at about 2:00 p.m. that afternoon so R35 needed to have her blood pressure and heart rate monitored frequently. ER doctor indicated monitoring of vitals should be able to be accomplished at the care center and parameters were given for when to notify if needed. ER final diagnoses included: minor head injury and accidental drug ingestion. On 3/24/25 at 1:15 p.m., a progress note indicated R35 returned from the ER at approximately 11:00 a.m., vital signs were obtained upon her return with BP being 193/103 and 191/118 and her HR was 75 and 76 bpm. New orders indicated for staff to administer	F 760		

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F 760	Continued From page 16 morning scheduled doses of duloxetine, potassium, preservision, and sucralfate; staff to hold morning doses of Tylenol, lisinopril (ACE inhibitor- heard medication), protonic (for gastric reflux, and furosemide (diuretic) and resume usual medications orders on 3/25/25; and for staff to check BP and HR hourly until 4:00 p.m., then every four hours for the next 24 hours - and to notify on call provider if R35's heart rate is less than 50 bpm or systolic blood pressure (SBP) is less than 100. On 3/25/25 at 9:48 a.m., registered nurse (RN)-B sent a message to nurse practitioner stating "Resident was given another residents medications yesterday and following meds had a fall in the bathroom. We sent her to the ER; Resident per ER was to have BPs every hour until 4:00 p.m. and then every four hours for 24 hours. BPs and HRs were not consecutively gotten. Staff was to update MD on call is SBP was less then 100 or HR was less then 50 bpm. All SBPs that were taken were greater then 140 and all HRs were greater than 65. BPs and HRs were taken hourly upon readmission at 11:00 a.m. until 2:00 p.m. then not again until 10:40 p.m., then has been every four hours since then." On 3/25/25 at 1:03 p.m., nurse practitioner responded that staff could go back to standard vital checks with no further monitoring needed. On 4/9/25 at 3:36 p.m., RN-C stated on 3/24/25, during the morning medication pass, she set up multiple residents' medications in med cups that she initialed with their first and last name initials and placed them in the top drawer of the medication cart to administer at a later time. RN-C stated when she went to administer R35's medications, she gave R35's another resident	F 760		

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F 760	Continued From page 17 medications as she had mislabeled the medication cup. RN-C stated when she realized the error, she notified the RN clinical coordinator immediately who instructed her to wait 30 minutes and to then obtain R35's vital signs as that would be when the medications could start working. RN-C stated R35 then fell approximately 30-40 minutes after she had administered her the wrong medications. RN-C was removed from passing medications and had to complete an education module on medication administration. RN-C was told she needed to leave the facility pending investigation. RN-C had since been re-educated and was now aware that pre-preparing medications was not an acceptable practice, and she would not be doing it in the future. On 4/9/25 at 4:47 p.m., consultant pharmacist (Pharm D) stated after she reviewed the medications R35 received in error, she was concerned about R35's blood pressure as she received high doses of blood pressure medications and seizure medication. Per email from Pharm D to the facility: "Based on the medications received, particularly higher doses and multiple medication classes, I do think it is likely that the fall was a result of the medication error. Primidone alone has an onset of as little as 30 minutes. Many of the other medications have a peak within an hour." Pharm D stated it would not be acceptable for nurses to prepare more than one person's medications at one time ever. Pharm D stated due to the multiple significant medications that were not R35's, she would consider this a significant medication error. On 4/10/25 at 10:11 a.m., the director of nursing (DON) stated the process of passing medications	F 760		

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F 760	Continued From page 18 staff was to follow the medication rights, and to prepare medications for one resident at a time. The policy was not followed by RN-C on 3/24/25. The facility had reviewed the medication administration and medication incident policy, revised the medication administration standards policy, reviewed R35's care plan, started medications administration audits, and education was provided to nurses in regard to medication pass expectations. DON stated it was not appropriate for staff to pre-set-up medications and place them in the top drawer of the medication cart to administer at a later time as that can lead to a medication error. The facility Medication Administration policy dated 2/2025, identified staff administering medication would perform ongoing monitoring of the resident's response to medications administered. Medications are to be administered in a timely manner, accurately and in a way to allow for maximum benefit. Personnel administering medications practice safe medication administration including the correct process for resident identification. Medications will not be prepared without the intent to administer, known as pre-pouring or pre-setting. The facility implemented corrective action to prevent recurrence by 3/28/25 when the facility completed the following: Reviewed and revised medication administration policies, provided education to all staff members responsible for medication administration, which included administration of medications and ensuring the six rights of medication administration was being followed, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview,	F 760		

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F 760	Continued From page 19 and document review on 4/10/25.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 29, 2025

Administrator
Cura Of Sauk Centre
425 N Elm Street
Sauk Centre, MN 56378

Re: State Nursing Home Licensing Orders
Event ID: LIVS11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 10, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

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

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00640	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF SAUK CENTRE	425 N ELM STREET SAUK CENTRE, MN 56378

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2 000	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 4/7/25 through 4/10/25, a 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 Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53412402C (MN00111124) and H53412382C (MN00108615). NO citations were issued. The following complaints were reviewed: H53412384C (MN00111714) with licensing orders issued at 1545. 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 surveyors 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R6) reviewed for urinary tract infections (UTI).	2 555	R6s careplan was updated on 4/10/25 to reflect R6s history of urinary tract infections with atypical symptoms including increase confusion and agitation, currently taking diuretic, opioid, cathartic medications.	5/14/25

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2 555	Continued From page 3 Findings include: R6's significant change Minimum Data Set (MDS) dated 1/31/25, identified R6 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R6's diagnoses included hypertension, renal insufficiency, thyroid disorder, arthritis, non-Alzheimer's dementia, depression, respiratory failure, chronic respiratory failure with hypoxia, mononeuritis multiplex, morbid obesity and dependence on supplemental oxygen. R6's face sheet, print date of 4/9/25, included a diagnosis of urinary tract infection (UTI). R6's electronic health record indicated the following UTI history: 10/30/24 - was diagnosed with a UTI and was started on Cephalexin (antibiotic) 500 mg every 12 hours for seven days. 11/15/24 - was diagnosed with a UTI and was started on Bactrim (antibiotic) 800-160 mg twice daily for ten days. 12/10/24 - was started on methanamine hippirate (antibacterial medication)- one gram twice daily for recurrent UTI's. 1/9/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days 2/11/25 - was started on a cranberry supplement 500 mg twice daily for recurrent UTI's 3/20/25 - diagnosed with a UTI and was started on Cephalexin 500 mg every 12 hours for seven days. R6's physician orders, print date of 4/9/25, indicated an order for methenamine Hippurate (antibacterial medication used primarily to prevent	2 555	An audit will be completed of all residents with history of urinary tract infection. All residents that have recurrent urinary tract infections care plan will reflect their personal history of urinary tract infections. Infection preventionist during interdisciplinary team meetings will review residents identified with recurrent infections and ensure Careplan is updated appropriately. Reeducation was provided to Clinical Coordinators, MDS Coordinator,Infection Preventionist whom are involved in the direct development of resident care plans on the need to assure that infections and recurrent infections are added to resident care plans. Additionally a new infection checklist will be implemented that will include a reminder to initiate a careplan for infection at the time of occurrence, a reminder for infection preventionist to assure careplan reflects recurrent infections and appropriate monitoring and interventions. Current CarePlan's, Comprehensive Person-Centered Policy will be reviewed, and revisions will be made as needed.	

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2 555	Continued From page 4 and treat urinary tract infections) - one gram by mouth twice daily for recurrent UTI's. R6's care plan, print date of 4/9/25, did not include R6's urinary tract infection, R6's history of urinary tract infections, goals of treatment, and interventions allowing the nurse to assess the intervention's outcome and potentially revise care based on the resident's status. During interview on 4/10/25 at 9:58 a.m., registered nurse (RN)-A clinical coordinator stated the clinical coordinators are responsible for updating the resident's care plans. RN-A stated if a resident had an history of UTI's it should be included in the care plan so staff are watching for signs and symptoms and could recognize them earlier to treat the UTI sooner. RN-A stated it was important to include history of UTI's on the care plan to help with implementation of interventions or staff being aware so symptoms could be recognized and acted on. RN-A confirmed R6's care plan did not include that R6 had a history of UTI's or goals/interventions to prevent and treat UTI's. During interview on 4/10/25 at 10:06 a.m., director of nursing (DON) stated each discipline of practice completes their section on the resident's care plan. DON stated medical or nursing related issues were completed by the clinical coordinators. DON stated she would expect staff to update the RN clinical coordinator with any changes with the resident. DON stated if a resident had a history of UTI's, she would expect that to be included in their care plan. DON stated it was important so staff can know that R6 is susceptible to UTI's and that all steps are taken such as, thorough cares, increasing fluids and noticing the symptoms that R6 displays with UTI's	2 555	The Director or Nursing and/or designee will conduct audits of resident care plans to assure infections are care planned. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

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2 555	Continued From page 5 so we can respond quickly with treatment. The facility Care Plans, Comprehensive Person-Centered policy, dated 2/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practical able physical, mental, and psychosocial well-being. c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. d. Incorporate identified problem area. e. Incorporate risk factors associated with identified problems f. Reflect the resident's expressed wishes regarding care and treatment goals. g. Reflect treatment goals, timetable and objectives in measurable outcomes. h. Identify the professional services that are responsible for each element of care: i. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. j. Reflect currently recognized standards of practice for problem areas and conditions. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an	2 555		

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2 555	Continued From page 6 interdisciplinary process. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		5/9/25

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21535	Continued From page 7 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication regimens were free of unnecessary psychotropic drugs for 3 of 6 (R20, R43 and R6) residents reviewed who had orders for antianxiety medications beyond 14 days without documented rational. Findings include: R20's significant change Minimum Data Set dated 2/26/25, identified severely impaired cognition with diagnosis of Alzheimer's dementia. R20's order listing report dated 4/10/25, identified an order for prn (per requested need) for Ativan (an antianxiety medication) oral tablet 0.5 mg (milligrams) to be given by mouth every 4 hours as needed for terminal agitation with a start date of 2/28/25 and an end date of 2/21/26. R20's care plan dated 2/5/25, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety medication and directed staff to ensure minimum effective therapeutic dosing. R20's February 2025 medication administration	21535	R20, R43 and R6 providers were contacted and clinical rationales were obtained for as needed antianxiety medications beyond 14 days. An audit was completed to assure that all residents with as needed antianxiety medications had a clinical rational for extending beyond 14 days of use. A new assessment was built and implemented within the facility's electronic health record. All residents that receive as needed psychotropic medications beyond 14 days will have reviewed by nursing and provider to identify an appropriate clinical rationale and appropriate end date for use. This new assessment was completed for all affected residents. Reeducation was completed with Clinical Coordinators, MDS coordinator on the requirement for as needed end dates and	

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21535	Continued From page 8 record (MAR) indicated she had not used prn Ativan. R20's March 2025 MAR indicated she had used prn Ativan one time. R20's April 2025 MAR indicated she had not used prn Ativan. When reviewed on 4/10/25, R20's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. R43's quarterly MDS dated 2/28/25, identified intact cognition and a diagnosis of anxiety. R43's order listing report dated 4/10/25, identified an order for prn Ativan oral tablet 0.5 mg by mouth one time a day for anxiety and give 0.5 mg by mouth as needed for anxiety with a start date of 4/7/25 and an end date of 10/3/2025. R43's care plan dated 8/27/24, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety and directed staff to ensure minimum effective therapeutic dosing. R43's April 2025 MAR indicated she had used prn Ativan two times. When reviewed on 4/10/25, R43's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. R6's significant change Minimum Data Set dated, 1/31/25 identified severely impaired cognition, diagnoses of Alzheimer's dementia. R6's order listing report dated 4/9/25, identified an order for prn (per requested need) for Ativan (an antianxiety medication) oral tablet 0.5 mg (milligrams) to be given by mouth every 4 hours	21535	clinical rationale, the new assessment in the electronic health record. The Director or Nursing and/or designee will conduct audits of as needed psychotropics to assure appropriate end dates and clinical rationales are present. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

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21535	Continued From page 9 as needed for terminal agitation with a start date of 2/13/25 and an end date of 1/12/26. R6's care plan print date of 4/9/25, identified the potential for adverse drug interactions related to the use of multiple medications including an antianxiety medication and directed staff to ensure minimum effective therapeutic dosing. R6's February medication administration record (MAR) indicated she had not used any prn Ativan. R6's March 2025 MAR indicated she had not used any prn Ativan. R6's April 2025 MAR indicated she had not used any prn Ativan. When reviewed on 4/10/25, R6's medical record lacked evidence of any provider rationale for continuation of the prn ativan beyond 14 days. When interviewed on 4/9/25 at 4:47 p.m., the pharmacy consultant (Pharm D) stated a review of resident medications was completed monthly including any psychotropic (drugs that affect thoughts, behaviors, mood and perception) medications. The Pharm D stated any prn psychotropic medication including antianxiety medications such as Ativan were to be ordered only for a 14-day period and any continuation beyond that timeframe required review by and a statement of clinical rationale by the resident's provider. The Pharm D confirmed there was no documented clinical rationale for the extended prn Ativan orders for R20, R43 and R6 and she should have made this recommendation to their providers. When interviewed on 4/10/25 at 9:29 a.m., the director of nursing (DON) stated the facility process for review of psychotropic medications	21535		

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21535	Continued From page 10 was done by the facility interdisciplinary team (IDT) monthly. The DON stated her expectation for R20's, R43's and R6 prn antianxiety medication orders would have been to have had a 14-day end date or review and provider clinical rationale for continued use and acknowledged this had been missed for R20, R43 and R6. The facility policy Psychotropic Medication Management-Long Term Care dated 10/2023, identified "As needed orders for psychotropic drugs (with the exception of anti-psychotics) are limited to 14 days. Unless, the attending physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days in which case he/she should document their rationale in the resident's medical record and indicate the duration for the as needed order. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use.	21535		

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21535	Continued From page 11 Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **03 - NURSING HOME MAIN** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF SAUK CENTRE	**425 N ELM STREET SAUK CENTRE, MN 56378**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/09/2025. At the time of this survey, Cura of Sauk Centre Nursing Home Building 03 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/09/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Cura of Sauk Centre Nursing Home building 03 is a complete remodel and is a 2-story building addition with no basement, remodel of 27 resident rooms, and is fully fire sprinkler protected. Construction was completed in 2023. Construction type is determined to be Type II (111). This building consists of 3 smoke compartments.

The facility has a fire alarm system with smoke

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to maintain smoke and fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.6, and 4.6.12.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.1.5.1. These deficient findings could have a widespread impact on residents within the facility.	K 761	Most of the deficient fire and smoke barrier doors identified during the April 9, 2025, annual fire marshal inspection were repaired or replaced by a qualified contractor. The Maintenance Director verified completion of the work, and documentation of repairs is on file. Two deficient fire/smoke barrier doors identified during the annual inspection will	5/9/25

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K 761	Continued From page 3 Findings include: On 04/09/2025 between 9:00 and 10:30 AM, it was revealed by review of available documentation that several fire and smoke barrier doors had deficiencies that were discovered during the annual Fire Door Inspection that took place on February 5, 2025. Repairs had not been made to these doors at the time of the survey. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761	be replaced upon arrival of the doors. Mid Central Door has been contracted to install and certify compliance with NFPA 80 standards. In the interim, the Maintenance Director is conducting weekly inspections to ensure temporary measures are maintained. This alleged deficient practice has the potential to impact all residents, staff, and visitors within the facility due to the fire safety implications of non-compliant fire and smoke barrier doors. The Maintenance Director received re-education on the existing Life Safety Code and NFPA 80 standards regarding annual fire and smoke door inspections and prompt repair protocols. Audits on the doors to assure they are in compliance will be completed by the Maintenance Director. The Maintenance Director will conduct weekly audits of fire-rated and smoke barrier doors for three months to ensure they remain in compliance. After the weekly audits are completed, the Maintenance Director will be conducting monthly audits for three additional months. Findings will be documented during the six months of audits and reviewed at the QAPI meetings. Doors have been ordered. The company the doors have been ordered from gave the facility a lead time of 16-18 weeks. Doors should be compliant within the next 6 months.	