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 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	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
F0000	INITIAL COMMENTS On 3/4/26 through 3/5/26, a standard abbreviated survey was conducted at your facility. 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: H54547560C (2792390) with a deficiency issued at F656 and F880. 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 that substantial compliance with the regulations has been attained.	F0000		04/15/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10,	F0656	R2 and R3 no longer reside at the facility. An audit will be completed of residents who require the use of Enhanced Barrier Precautions (EBP) to assure their care plans accurately reflects their need for EBP. Education will be provided to facility nurses on the need to ensure resident's care plans include the need for EBP when warranted. The Director of Nursing or Designee will complete audits of resident care plans to ensure EBP's are included within the resident's care plan. Audits will be completed weekly for 4 weeks, and then monthly until next Quality Assurance meeting. Results of the audits will be reviewed with the QA committee at which time the need for and frequency of ongoing audits will be determined.	04/15/2026

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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F0656 SS = D	Continued from page 1 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 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 observation, interview and document review the facility failed to develop care plans to include enhanced barrier precautions (EBPs) for 2 of 3 residents when nursing assistant (NA)-A was observed lacking required personal protective equipment (PPE) while performing high contact care for R2 who required EBPs. Findings include: During observations on 3/4/26 at 1:05 p.m., an Enhanced Barrier Precautions sign was observed on the door for R2's room, with a personal protective equipment (PPE) cart outside the door. NA-A was observed at the side of R2's bed, wearing only gloves and a mask as PPE. Registered Nurse (RN)-A, an agency nurse, entered the room with a mask, gloves, and a gown. RN-A failed to inform NA-A a gown was also required as a part of the necessary PPE during high-contact cares for R2. NA-A	F0656		

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F0656 SS = D	Continued from page 2 proceeded to assist RN-A with positioning R2. NA-A reached over R2 to turn her to her right side, as R2 did not participate in her own bed mobility. NA-A held R2 on her side while RN-A performed wound care to her coccyx (tailbone area). R2's admission minimum data set (MDS), dated 2/23/26, indicated R2 had diagnoses of Alzheimer's Disease and a stage IV pressure ulcer. Her MDS also indicated she had severely impaired cognition, was dependent on staff for all cares and mobility. R2's care plan, dated 2/17/26, directed assistance of 1-2 staff for all cares, but lacked direction to use EBPs with high-contact care. During an interview on 3/4/26 at 9:52 a.m., nursing assistant (NA)-A, an agency aide, stated she was provided with verbal instructions to properly care for each resident when she started at the facility on 2/23/26. NA-A stated she had not been shown how to access each residents' care plans. During an interview on 3/4/26 at 1:20 p.m., RN-A stated, "I should have probably told her to gown up", when asked if NA-A was lacking required PPE during R2's care. During an interview on 3/4/26 at 1:25 p.m., NA-A stated she noticed RN-A entered the room with a blue gown on but did not know she was supposed to wear a gown. NA-A stated she did not see the EBP sign on R2's door. She stated she saw the PPE cart, in the hall next to R2's door, but was not aware it was intended for R2. NA-A stated she was aware of the EBP practice and knew it was to reduce the spread of germs. During an interview on 3/4/26 at 1:35 p.m., the ADON/infection control nurse stated EBPs should be used for residents identified when performing high-contact cares, including gown and gloves. She stated the RN should have said something to the NA regarding the need to wear a gown. She stated the NA's are to reference the Kardex (developed from the care plan) to determine care and precautions required for each resident. ADON stated she missed adding EBPs to the care plan for R2.	F0656		

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F0656 SS = D	Continued from page 3 A facility policy, Enhanced Barrier Precautions (EBPs), dated 1/26 directed EBPs was an infection control intervention designed to reduce transmission of multi-resistant drug organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. Further the policy indicated the use of EBPs within the facility was recommended by the Center for Disease Control (CDC). A facility policy, Care Plans Comprehensive Person-Centered, dated 2/2025 directed the comprehensive, person-centered care plan will: incorporate identified problem-areas and incorporate risk factors associated with identified problems. The policy indicated that the care plan must reflect currently recognized standards of proactive for problem areas and conditions and identify problem areas and their causes and develop interventions that are targeted and meaningful to the residents.	F0656		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	R2 and R3 no longer reside at the facility. Appropriate infection control practices including, Enhanced Barrier Precautions will be completed and followed for R1 and other residents within the facility per facility protocol. The facility will complete reeducation with nursing staff. The reeducation will include a review of infection control practices including enhanced barrier precautions, appropriate hand hygiene practices during wound care, between cares, and between glove changes. The Director of Nursing or designee will complete audits resident cares to ensure appropriate implementation of enhanced barrier precautions and hand hygiene is being completed with resident's cares. Audits will be completed 3 x a week for 4 weeks, and then weekly until next Quality Assurance meeting. Results of the audits will be reviewed with the QA committee at which time the need for and frequency of ongoing audits will be determined.	04/15/2026

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F0880 SS = D	Continued from page 4 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow established infection control practices for 3 of 3 residents (R1, R2, R3) on enhanced barrier precautions (EBPs) while performing	F0880		

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F0880 SS = D	Continued from page 5 high-contact care. Findings include: During an observation on 3/4/26 at 7:05 a.m., licensed practical nurse (LPN)-A and the director of nursing (DON) performed wound care for R1. - The DON removed two dressings on R1's left foot, discarded them and removed her gloves. The DON failed to perform hand hygiene prior to applying new gloves. She used wound cleanser and gauze to clean the stage II (partial thickness skin loss) left heel wound. She applied calcium alginate (a highly absorbent dressing that creates a moist healing environment) and covered with a bordered foam dressing. Following the application of the dressings to the left heel, the DON changed her gloves but failed to perform hand hygiene. - The DON cleansed the stage III (full thickness skin injury that involves full-thickness skin loss, resulting in exposure of the fatty tissue beneath) left lateral foot wound using wound cleanser and gauze. She measured the wound. She failed to change her gloves and perform hand hygiene. The DON proceeded to complete the treatment using skin prep, applied collagen to the wound bed, and covered with a bordered foam dressing. The DON changed her gloves and performed hand hygiene. - The DON observed R1's foley catheter (a flexible indwelling tube inserted into the bladder to drain urine) lying in her bed. The DON discarded her gloves and applied sterile gloves but failed to perform hand hygiene, before attempting to place the foley catheter into R1's urethra (the tube-structure that transports urine from the bladder to outside of the body) with her right hand, as she used her left hand to position R1's genitalia. When there was no urine return, she removed the sterile gloves, opened a new catheter kit, and applied sterile gloves without performing hand hygiene. The DON used her right hand to attempt to place the foley catheter into R1's urethra and her left hand to position R1's genitalia again but was unsuccessful. The DON discarded her gloves and opened a new catheter kit without performing hand hygiene prior to applying the sterile gloves. The DON placed the Foley catheter and inflated the balloon intended to maintain its placement in the bladder. - The DON failed to change her gloves and perform hand hygiene before she removed the abdominal (ABD) pad and gauze packing from R1's stage IV coccyx wound and her stage IV left gluteal (buttocks) fold wound. She	F0880		

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F0880 SS = D	Continued from page 6 discarded the dressings, changed her gloves, and washed her hands. - Then the DON held the paper tape measure to the coccyx wound to determine measurements, then moved the tape measure to the bedside table with the backside of the tape measure touching the table four times, as she documented the wound measurements with the marker. The DON failed to change her gloves or perform hand hygiene, then used another paper tape measure to assess the left gluteal fold wound. - The DON moved all the used paper tape measures on top of an open box of facial tissues. Then she used wound cleanser and gauze to clean the coccyx wound and left gluteal fold wound, failing to change her gloves or perform hand hygiene between cleaning the two wounds. After cleaning the wounds, she discarded her gloves and washed her hands. She applied new gloves and packed the coccyx wound with gauze and covered with a new ABD pad, securing it in place with tape. The DON then placed all the used paper tape measures on the flap of the open box of ostomy bags (medical appliance bags used to collect stool through an opening in the abdominal wall). Then the DON removed her gloves and performed hand hygiene. - The nurses failed to disinfect the over the bed table where the soiled paper tape measures had been placed before exiting the room. R1's quarterly MDS dated 12/8/25 indicated she had diagnoses of Type 2 Diabetes Mellitus, paraplegia, encephalopathy and had two stage III pressure ulcers, one stage IV pressure ulcer, and one deep tissue injury. Her MDS indicated she was cognitively intact and was dependent on staff for all cares and mobility. R1's care plan dated 2/12/25 indicated R1 was on EBP's per CDC recommendations for wounds with a goal to remain free of multidrug-resistant organisms (MDRO). During an observation on 3/4/26 at 1:05 p.m., an Enhanced Barrier Precautions (EBP) sign was observed on the door for R2's room, with a personal protective equipment (PPE) cart outside the door. NA-A was observed standing at the edge of R2's bed, wearing only gloves and a mask as PPE. Registered Nurse (RN)-A, an agency nurse, entered the room with a mask, gloves, and a gown. RN-A failed to inform NA-A that a gown was also required as a part of the necessary PPE during	F0880		

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F0880 SS = D	Continued from page 7 high-contact cares for R2. NA-A proceeded to assist RN-A with positioning R2, as NA-A's scrubs were in contact with R2/s bedding and handrail. NA-A reached over R2 to turn her to her right side, as R2 was unable to participate in her own bed mobility. NA-A held R2 on her side while RN-A performed wound care to her coccyx (tailbone area). R2's admission minimum data set (MDS), dated 2/23/26, indicated R2 had diagnoses of Alzheimer's Disease and a stage IV (severe, full thickness wound extending to exposed muscle, tendon, or bone) pressure ulcer. Her MDS also indicated she had severely impaired cognition, was dependent on staff for all cares and mobility. R2's care plan, dated 2/17/26, directed assistance of 1-2 staff for all cares, but lacked direction to use EBPs with high-contact care. During an interview on 3/4/26 at 1:20 p.m., RN-A stated, "I should have probably told her [NA-A] to gown up", following R2's care. During an interview on 3/4/26 at 1:25 p.m., NA-A stated she noticed RN-A entered R2's room with a blue gown but did not know she was supposed to wear a gown as well. NA-A stated she had been providing care for R2 for a couple of weeks and had never worn a gown. She stated she did not see the EBP sign on R2's door. She stated she saw the PPE cart, in the hall next to R2's door, but was not aware it was intended for R2. NA-A stated she was aware of the EBP practice and knew it was intended to reduce the spread of germs. During an observation on 3/5/26 at 9:06 a.m., the DON performed wound care, with the assistance of the ADON for her wounds to R3's stage III coccyx wound and her stage IV left gluteal wound. The DON held the paper measuring tape to the coccyx wound, then wrote the measurements with a marker on the tape. Red liquid was observed on the back of the paper measuring tape. The DON placed the tape directly on R3's bedside table, touching her water mug. The DON changed her gloves but failed to perform hand hygiene before she measured the left gluteal wound with a new paper tape measure. She wrote the measurements with a marker. At the completion of the wound care, the DON picked up the marker and paper tape measures with her bare hands and placed the marker and soiled tape measures in the right pocket of	F0880		

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F0880 SS = D	Continued from page 8 her scrubs. The nurses failed to disinfect the bedside table following the wound care. The DON placed the marker and soiled paper tape measures directly on the treatment cart, next to the laptop in the hallway. R3's was admitted on 2/24/26. Her minimum data set MDS was incomplete. R3's care plan dated 3/4/26 indicated R3 was on EBP's per CDC recommendations for wounds with a goal to remain free of multidrug-resistant organisms (MDRO). During an interview on 3/4/26 at 9:52 a.m., nursing assistant (NA)-A, an agency aide, stated she was provided with verbal instructions to properly care for each resident when she started at the facility on 2/23/26. NA-A stated she had not been shown how to access each residents' care plan. During an interview on 3/4/26 at 1:35 p.m., the ADON/infection control nurse stated EBPs should be used for residents identified to require EBPs when performing high-contact cares, including gown and gloves. She stated the RN-A should have said something to the NA-A regarding the need to wear a gown. She stated the NA's are expected to reference the Kardex (developed from the care plan) to determine care and precautions required for each resident. The ADON stated she missed adding EBPs to the care plan for R2 when she was admitted with a wound. During an interview on 3/5/26 at 9:30 a.m., the ADON and infection control nurse stated the soiled tape measures had the possibility to spread infection and should not be placed on the treatment cart. She stated hand hygiene should be performed between glove changes, after cleansing each wound, after measuring each wound, and before providing care to the next wound to reduce the spread of infection. During an interview on 3/5/26 at 9:35 a.m., the DON stated it was necessary to change gloves after cleaning each wound and between treatments for each wound. She stated there was potential for contamination from one wound to the other. She stated placing the used tape measures on the treatment cart that could contaminate the surface with germs.	F0880		

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F0880 SS = D	Continued from page 9 During an interview on 3/5/26 at 11:03 a.m., the medical director (MD) stated the importance of infection control measures such as appropriate hand hygiene and proper use of PPE to prevent the spread of infection. A facility policy, Handwashing/Hand Hygiene, dated 9/2025, directed this facility considers hand hygiene the primary means to prevent the spread of infections. Use of an alcohol-based hand rub containing at least 62% alcohol; or alternatively soap and water before performing and non-surgical procedures, before and after handling an invasive device, before donning sterile gloves, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after handling used dressings or contaminated equipment, after removing gloves. Further, the policy indicated the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. A facility policy, Personal Protective Equipment (PPE), dated 1/2026, directed gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments. Wash hands after removing gloves (Note: Gloves do not replace handwashing.) A facility policy, Enhanced Barrier Precautions (EBPs), dated 1/2026 directed EBPs was an infection control intervention designed to reduce transmission of multi-resistant drug organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. Further the policy indicated the use of EBPs within the facility was recommended by the Center for Disease Control (CDC). EBPs are indicated for residents with any of the following: 1. Infection or colonization with a CDC targeted (MDRO when Contact Precautions do not otherwise apply; OR 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.	F0880		

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F0880 SS = D	Continued from page 10 EBP of utilizing a minimum of a gown and glove use will be initiated for high-contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care for stage 2 pressure ulcers, diabetic ulcers, venous stasis ulcers, arterial ulcers, open surgical wounds.	F0880		

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SANDSTONE HEALTH CARE CENTER	**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
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 3/4/26 through 3/5/26, a complaint 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 licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/15/2026

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

Minnesota State 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 **03/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	**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
20000	Continued from page 1 The following complaints were reviewed: H54547560C (2792390) with a licensing order issued at 4658.0405 Subp 1. 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 14-01, available at 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 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	20555	Corrected.	04/15/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	**109 COURT AVENUE SOUTH , SANDSTONE, Minnesota, 55072**

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20555	Continued from page 2 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop care plans to include enhanced barrier precautions (EBPs) for 2 of 3 residents when nursing assistant (NA)-A was observed lacking required personal protective equipment (PPE) while performing high contact care for R2 who required EBPs. Findings include: During observations on 3/4/26 at 1:05 p.m., an Enhanced Barrier Precautions sign was observed on the door for R2's room, with a personal protective equipment (PPE) cart outside the door. NA-A was observed at the side of R2's bed, wearing only gloves and a mask as PPE. Registered Nurse (RN)-A, an agency nurse, entered the room with a mask, gloves, and a gown. RN-A failed to inform NA-A a gown was also required as a part of the necessary PPE during high-contact cares for R2. NA-A proceeded to assist RN-A with positioning R2. NA-A reached over R2 to turn her to her right side, as R2 did not participate in her own bed mobility. NA-A held R2 on her side while RN-A performed wound care to her coccyx (tailbone area). R2's admission minimum data set (MDS), dated 2/23/26, indicated R2 had diagnoses of Alzheimer's Disease and a stage IV pressure ulcer. Her MDS also indicated she had severely impaired cognition, was dependent on staff for all cares and mobility. R2's care plan, dated 2/17/26, directed assistance of 1-2 staff for all cares, but lacked direction to use EBPs with high-contact care. During an interview on 3/4/26 at 9:52 a.m., nursing assistant (NA)-A, an agency aide, stated she was provided with verbal instructions to properly care for each resident when she started at the facility on 2/23/26. NA-A stated she had not been shown how to access each residents' care plans.	20555		

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

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20555	Continued from page 3 During an interview on 3/4/26 at 1:20 p.m., RN-A stated, “I should have probably told her to gown up”, when asked if NA-A was lacking required PPE during R2’s care. During an interview on 3/4/26 at 1:25 p.m., NA-A stated she noticed RN-A entered the room with a blue gown on but did not know she was supposed to wear a gown. NA-A stated she did not see the EBP sign on R2’s door. She stated she saw the PPE cart, in the hall next to R2’s door, but was not aware it was intended for R2. NA-A stated she was aware of the EBP practice and knew it was to reduce the spread of germs. During an interview on 3/4/26 at 1:35 p.m., the ADON/infection control nurse stated EBPs should be used for residents identified when performing high-contact cares, including gown and gloves. She stated the RN should have said something to the NA regarding the need to wear a gown. She stated the NA’s are to reference the Kardex (developed from the care plan) to determine care and precautions required for each resident. ADON stated she missed adding EBPs to the care plan for R2. A facility policy, Enhanced Barrier Precautions (EBPs), dated 1/26 directed EBPs was an infection control intervention designed to reduce transmission of multi-resistant drug organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. Further the policy indicated the use of EBPs within the facility was recommended by the Center for Disease Control (CDC). A facility policy, Care Plans Comprehensive Person-Centered, dated 2/2025 directed the comprehensive, person-centered care plan will: incorporate identified problem-areas and incorporate risk factors associated with identified problems. The policy indicated that the care plan must reflect currently recognized standards of proactive for problem areas and conditions and identify problem areas and their causes and develop interventions that are targeted and meaningful to the residents. SUGGESTED METHOD OF CORRECTION: The DON or designee could provide education to nurse's responsible to establish care plans and conduct care plan audits for all residents who require enhanced precautions. The DON	20555		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20555	Continued from page 4 or designee could share the findings of the audits with the Quality Assessment Performance Improvement Committee (QAPI) to monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 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 Cycle March 5, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1F26A4-H1

Dear Administrator:

The above facility survey was completed on March 5, 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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,

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

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: Reinspection Results
Event ID: 1F26A4-H2

Dear Administrator:

On April 21, 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 March 5, 2026. At this time these correction orders were found corrected.

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

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