

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Cura of Willmar		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Willmar Avenue Southwest Willmar, MN 56201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop and implement a process to ensure the wander alert system was in working order. This had the potential to affect 2 of 2 residents (R1, R2) who utilized a wander alert device. Findings include: R1's admission Record indicated he admitted to the facility 2/23/24. Diagnosis included vascular dementia, Alzheimer's disease and bilateral below the knee amputations. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified a memory problem and delusions. The MDS indicated R1 did not wander during the assessment period and wore a wander alert device daily. R1's care plan dated 9/3/25, identified a high risk for elopement and directed staff to provide one to one supervision while awake and 15-minute checks while in bed. The care plan indicated R1 had wander device bracelets placed on his left wrist and on the back of his wheelchair. Facility incident report dated 8/24/25, indicated R1 was able to exit the facility via the front entrance doors, wander guard did not work. Nursing students observed R1 exiting the building and assisted him back inside and alerted staff. The report indicated the door had recently been open and had not locked which allowed R1 to exit the facility. Facility incident report dated 9/1/25, indicated Staff noted the wander guard alarm for R1's unit was sounding. Staff found R1 in the water in the tall grass in a culvert on the west side of the building with his wheelchair on top of him. The report indicated R1 was able to push and hold the exit door long enough for the emergency release to activate, allowing the door to open. During interview on 9/5/25 at 7:30 a.m., the administrator stated the facility did not currently have a maintenance director and had not for only about two weeks. The administrator said they had the maintenance staff from another facility come and look at the doors to ensure everything was working properly. She said everything was reported to be working fine. During interview on 9/5/25 at 7:52 a.m., the regional director of operations (RDO) stated the wander alert system was checked every Monday. The RDO stated there were two options for checking the doors, a testing device, handheld remote or using a FOB (transmitter). The RDO said the doors were checked using a handheld remote. During observation on 9/5/25 at 9:36 a.m., the RDO used the handheld remote to check the facility doors that had a wander alert system. The doors alarmed and locked when tested. During interview on 9/5/25 at 9:03 p.m., nursing assistant (NA)-A stated the doors alarmed when R1 was near but did not physically lock and said it had happened 4-5 times. During interview on 9/9/25 at 12:15 p.m., licensed practical nurse (LPN)-A stated she was working when R1 was found outside the facility. LPN-A said she felt the issue was the door had not been locking and said it had been reported to management. During interview on 9/9/25 at 12:39 p.m., NA-A stated it was pretty common knowledge the door had not been locking and said the issue had been going on for about 3-4 weeks. NA-A said it had been reported. During interview on 9/9/25 at 1:15 p.m., the administrator said the maintenance director from another facility had done an inspection of the doors to ensure they were working after R1 had eloped from the facility. During interview on 9/5/25 at 2:00 p.m., the maintenance director whom the administrator had been referring to, stated he had tested the doors at the facility on 8/26/25, but had not been out since. He said at that time the doors were functioning properly. During interview on 9/10/25, at 8:16 a.m., the former maintenance director said he did not think the doors would unlock if a wander alert device was near and said he never tested for that. The former maintenance director said he used a bracelet (transmitter) and checked the doors on Mondays to make sure they locked. He said the device checker never worked on the doors. The former maintenance director said he did not know who would be called if there were any technical issues with the wander alert system. During interview on 9/10/25 at 10:34 a.m., the RDO stated as far as he knew, the doors should not be able to unlock when pushed and held if the person was wearing a wander alert bracelet. The RDO said he had reached out to a third party who was going to send a technician to look at the system. DoorGUARDIAN Installation Manual dated 12/6/2023, indicated the following recommended weekly testing: Patient Escort Feature Test- Enter the monitoring zone with a transmitter on your ankle. The red light will turn on and the door will quietly lock. Enter the primary reset code and the light will turn green, and the door will unlock. Anti-tailgate Feature Test- With the door locked, apply pressure on the opening hardware of the door. The exit panel will begin to alarm, and the red light will remain on. The light will remain red and the audible alarm will sound. After 15 seconds the audible alarm will become a continuous tone and the door will release. Open the door, and the audible alarm will change to a seagull sound. Close the door and enter the reset code. The panel will stop alarming, and the door will re-lock. Remote Keypad test- repeat the steps</p>		