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 03/25/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to protect 1 of 1 resident (R1) from neglect when R1 experienced a fall from the toilet on 3/7/26 and unidentified staff assisted R1 back to bed without notification to nurse and assessment. This resulted in actual harm when R1 was later identified to be in pain, required emergency medical attention, and was diagnosed with closed fracture of left hip. R1 required surgical repair of the fracture. The facility implemented corrective action, and the deficient practice was corrected on 3/08/26, prior to the survey, and was issued at past non-compliance.^Findings include: Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1's diagnoses included stroke, hypertension, end stage renal disease (ESRD) , diabetes mellitus and cerebrovascular accident (CVA). R1 was cognitively intact, with no behaviors or wandering, required use of wheelchair or walker for mobility and assist of one for toileting. R1 was dependent on staff for sit to stand, chair to bed transfer and had not attempted to walk 10 feet or more. The MDS further indicated R1 was frequently incontinent of bowel and bladder. The MDS indicated he had a fall within the last two-six months prior to admission, no falls since admission and rarely experienced pain or had no pain at all.R1's Care Plan dated 2/02/26, indicated R1 had localized edema, hemiplegia and hemiparesis (hemiplegia is severe, resulting in complete paralysis of one side of the body, while hemiparesis is a milder form characterized by weakness, tingling) following cerebral infarction (stroke) affecting left non-dominant side and required assistance of two staff with ambulation, transfers and toileting. R1's Brief Interview for Mental Status (BIMS) dated 3/16/26, indicated R1 had a score of 15 out of 15 meaning he was cognitively intact. R1's Post Fall Investigation dated 3/07/26, indicated R1's current fall interventions were in place: bed at appropriate height; encourage to wear appropriate footwear; call light within reach; call light pinned in place; referrals to physical, occupational and speech therapy as indicated; and reposition resident per tissue tolerances and as needed. The investigation further indicated to encourage commode use (riser above toilet) assistance of two with transfers and the only other fall was on 2/01/26, while attempting to self-transfer. The investigation indicated the root cause was resident was transferred incorrectly. R1 was moved back into bed without assessment, multiple staff were terminated as result of this action and staff education was posted via forms. In addition, R1's care plan and Kardex were updated. R1's Emergency Department Note/History and Physical dated 3/07/26, indicated R1 had left hip pain and was diagnosed with closed fracture of left hip, end stage renal disease and atrial fibrillation (high heart rate). R1 was sent to another hospital for surgery for his fracture.A Facility Reported Incident (FRI) dated 3/08/26, indicated on 3/07/26 at 1:29 p.m., R1 reported to nurse on duty he tipped off the toilet. During the evening shift at approximately 7:45 p.m., nursing staff entered residents' room to check his blood sugar and resident was complaining of left leg pain, which had progressed from earlier reports of left knee pain during the day. When asked where the pain was located, the resident stated the pain had spread to his entire left leg. During (continued on next page)

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

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 03/25/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	assessment, the resident yelled out in pain with repositioning. Nursing assessment noted old, scattered bruising to the lower extremities and swelling noted to the left hip area. No new redness or bruising was observed at that time. When asked what had occurred, the resident reported that he had fallen earlier off the toilet. The resident was unable to recall the names of the staff who assisted him. Earlier in the day the resident had complained of left knee pain, stating that the pain comes and goes. Tylenol was given due to leg pain. At approximately 3:00 p.m., R1 stated the pain had subsided. A cold compress was offered but declined. Nursing staff reviewed the morning shift report, which indicated the resident had earlier report he had tipped off the toilet however staff reported they had not witnessed a fall. At approximately 7:13 p.m. due to worsening pain the resident stated it hurt so bad and went to the emergency department (ED) and it was identified the resident had a left femur fracture and was transferred to a different hospital. Facility Investigation dated 3/13/26, indicated R1 was transferred to the toilet by one employee. The resident care plan indicated he needed assistance of two staff with transfers. R1 reported he was sitting on the toilet and fell forward onto the floor while attempting to wipe himself. R1 stated he was blind, and two individuals assisted him up from the floor but could not recall who it was and was unable to give many details. Further investigation indicated that his wife reported that the resident told her he fell off the toilet but again could not give many details and had difficulty describing what had happened, but she stated it sounded like someone helped him off the floor, though he could not identify who assisted him. R1's spouse noted that it seemed someone asked the resident if he should see the nurse before assisting him. The resident later complained of pain in his leg and knee, particularly during physical therapy exercises and received Tylenol, which provided some relief but did not fully resolve the pain. The investigation indicated hospital documentation included the patient had fallen off the toilet earlier today landing on his left side. Patient reports pain in his left hip. R1 was brought to the emergency department (ED) for evaluation. X-rays showed mild displaced (significant movement of bone fragments out of their normal anatomical position) and angulated (a bend or angle at the fracture site) intertrochanteric fracture (hip fracture) of the proximal (femoral head, neck and trochanters, forming the hip joint) left femur. R1denied loss of consciences or head trauma. R1 was transferred to another hospital and underwent orthopedic surgery. R1's Physical Therapy Treatment Encounter Note dated 3/07/26 at 11:55 a.m., indicated R1 was seen by physical therapy assistant (PTA)-B and had precautions due to high blood sugar, falls, left sided weakness and was legally blind. The note indicated patient reporting fall from toilet however staff report no fall noted on this date. Left lower extremity knee, hip and intertrochanter band area pain reported with all movement with this session. Attempted transfer training from out of bed x three however left lower extremity pain not allowing for rise in spite of bed raised for improved ease. Care coordination with nursing to report findings of today's session. During interview on 3/23/26 at 4:23 p.m., R1 stated he slid off of the toilet while he was trying to wipe his butt, and his left leg hit the floor, and two nurses entered his room and just pulled me up. R1 stated he didn't know who they were because he was blind but just knew it was two staff who helped him off the floor, back into bed.During interview on 3/26/25 at 4:31 p.m., administrator stated she had interviewed all of the staff who were working on Saturday 3/07/26, and the activity assistant /nursing assistant (AA)-A stated she put R1 on the toilet before she went on her lunch break. AA-A stated she was informed by other staff working, R1 required assist of one for transfers. AA-A left R1 on the toilet with his call light and informed the other staff working she was going on her break. The administrator stated after she had interviewed nursing assistant (NA)-A, NA-B and NA-C none of them reported a fall and also could not state they assisted R1 from the floor into bed. After they had suspended all three NAs, it was decided to terminate all of three them as it was known someone had put him back into his bed and he had a fracture. During interview on 3/23/26 at 6:26 p.m., NA-A stated she did not work with R1 the day of his fracture and was informed by NA-C via Snap Chat (social media messaging platform) message that evening about R1's fall and fracture. NA-A stated the snap chat message mentioned for her to stick to the story about R1's fall, and NA-C put him back into bed. (continued on next page)

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 03/25/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	NA-A stated the message immediately disappeared, so she was unable to show proof of the message. NA-A stated she does not recall telling AA-A R1 was assist of one and does not recall AA-A telling her he was on the toilet before AA-A went on break.During interview on 3/23/26 at 7:11 p.m., NA-B stated she received a phone call the day of the fall from the director of nursing (DON) around 8:00 p.m. and was informed she was suspended pending investigation. NA-B stated she answered R1's call light around 1:30 p.m., the day of the fall, when R1 asked for Tylenol for his headache and she informed licensed practical nurse (LPN)-A. NA-B stated the next thing she knew, the DON told me we were all mandated reporters and we would all be let go. NA-B stated she did not see R1 fall and did not assist him off of the floor back into his bed.During interview on 3/24/26 at 9:30 a.m., NA-C stated it has been two weeks since the incident occurred, so it was hard to recall the events but did remember she got R1 up on 3/07/26. R1 went to lunch, they had chili. After lunch NA-C and NA-B put R1 back into bed between 11:30 am and 12:30 p.m. NA-C did not recall telling AA-A that she could transfer R1 to the toilet from his bed with assistance of one. NA-C did not recall AA-A report she was then going to leave R1 on the toilet and take her break. NA-C stated she never transferred R1 off the floor and back into bed and was not aware of him falling. In addition, NA-C stated she did send a Snap Chat to NA-A later in the evening on 3/07/26, asking her if anyone called her about the fall and that was the only thing she sent via Snap Chat. During interview on 3/24/26 at 10:59 a.m., with R1 and family member (FM)-A, R1 stated before the fall he stood up and was trying to wipe himself when he slid to the floor and two nurses came in and picked him up under his arms, then put him into bed. R1 stated he could not identify who they were as he was blind, but he knew they were women. FM-A stated she arrived on 3/7/26 around 1:00 p.m. R1 told her the same information, and he complained of leg pain. R1 received Tylenol and later that day the pain worsened, and he was sent to the hospital and had surgery.During interview on 3/24/26 at 12:56 a.m., AA-A stated she was working on 3/07/26, doing activities. It was a Saturday. AA-A stated she also helped with meals and answering call lights. After assisting with meals AA-A was heading for her break she noticed R1 was in bed and had his call-light on. R1 requested to use the bathroom. AA-A asked the staff working what assistance R1 needed for transfers and was told he was assist of one and transfer belt to the toilet. AA-A was asked to transfer him and leave his call light with him. AA-A was told, the staff working would transfer him off of the toilet and back into bed while AA-A was on her break. AA-A stated after her break she continued with activities for the day and found out later in the evening R1 had fallen and had a fracture.During interview on 3/24/26 at 1:40 p.m., physical therapy assistant (PTA)-A stated prior to R1's fall with a fracture he was assist of one with a gait belt in therapy. PTA-A stated he does not think it would be possible for him to transfer himself back into bed after he had a fall and a fracture. PTA-A stated someone must have transferred him back into bed that day after his fall. During interview on 3/25/26 at 9:40 a.m., regional nurse consultant stated she knows something happened with R1 with his fracture and felt the staff working just wouldn't come clean. Their stories didn't match up with each other's and continued to deny what happened, even after termination.During interview on 3/25/26 at 11:10 a.m., LPN-A stated she was the nurse working on 3/07/26, and one of the NAs told her R1 wanted Tylenol. When LPN-A went into R1's room, R1 reported he had fallen from the toilet. When LPN-A interviewed all of the NAs working that day, none of them said they saw him fall. LPN-A thought R1 was confused. LPN-A stated she was new at the facility, and it happened right at the end of her shift so LPN-A passed the information on to the evening shift. Facility Fall Communication undated, indicated all fall events must be reported to the nurse immediately, including witnessed, unwitnessed, near, and suspected falls. If a resident reports a fall, this must be reported to the nurse immediately as well. Staff must never fail to notify the nurse if they are aware that a fall occurred, as prompt reporting is necessary for proper assessment and care. Failing to report a fall may result in preventable harm to a resident and may lead to a reportable event. The facility corrected the deficient practice, which began on 3/7/26, on 3/08/26, prior to survey entrance on 3/23/26, by NA-A, NA-B and NA-C were terminated, transfer audits completed, education completed on facility's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Willmar	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	transferring, ambulation and falls policy. Therefore the deficiency is being issued at past non-compliance.