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	05/22/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure as needed (PRN) medications were administered per physician's order for 1 of 1 resident (R20) reviewed for unnecessary medications. Findings include: R20's quarterly Minimum Data Set (MDS) dated [DATE], identified R20 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R20's diagnoses included chronic diastolic congestive heart failure (type of heart failure that occurs when the heart's left ventricle is unable to fill with blood properly during the diastolic phase, when the heart relaxes), hypertension, peripheral vascular disease (chronic, progressive condition that occurs when blood circulation to a body part other than the heart or brain is reduced), Non-Alzheimer's Dementia, seizure disorder, anxiety disorder, asthma (inflammation and narrowing of the small airways in the lungs), respiratory failure (serious condition that make it difficult to breathe on your own), permanent atrial fibrillation (when atrial fibrillation is present all the time and no more attempts to restore normal heart rhythm will be made), and benign prostatic hyperplasia (non-cancerous condition in men where the prostate gland increases in size). R20's electronic health record (EHR) indicated a signed physician's order for Metolazone 5 mg (milligram) to be given by mouth as needed once daily for fluid retention/weight gain of three pounds overnight or five pounds in seven days related to chronic diastolic congestive heart failure. EHR lacked documentation of administration of PRN medication on 3/27/24, 3/31/24, 4/2/24, 4/10/24, 4/17/24 and 5/4/24. R20's weight documentation, in EHR, indicated increased weight gain overnight on the following dates: - 3/26/24 at 8:57 a.m., weight was documented as 165.6 lbs (pounds) - 3/27/24 at 9:04 a.m., weight was documented as 169.1 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. - 3/30/24 at 1:31 p.m., weight was documented as 167.8 lbs (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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Cura of Willmar		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Willmar Avenue Southwest Willmar, MN 56201	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/31/24 at 10:31 a.m., weight was documented as 183.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. - 4/1/24 at 8:47 a.m., weight was documented as 174.2 lbs - 4/2/24 at 9:30 a.m., weight was documented as 186.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. - 4/9/24 at 1:50 p.m., weight was documented as 175.2 lbs - 4/10/24 at 1:30 p.m., weight was documented at 186.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. - 4/16/24 at 9:13 a.m , weight was documented at 168.0 lbs - 4/17/24 at 12:39 p.m., weight was documented at 172.2 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. - 5/3/24 at 2:21 p.m., weight was documented at 171.0 lbs - 5/4/24 at 12:17 p.m., weight was documented at 175.0 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds. R20's progress notes lacked documentation of increased weight and if R20 was experiencing any signs or symptoms related to the increased weight. During observation on 5/21/24 at 1:34 p.m., R20 did not have any edema noted in his lower extremities. During interview on 5/22/24 at 9:40 a.m., licensed practical nurse (LPN)-A stated R20 did not have a PRN order related to his daily weights. LPN-A stated if R20's daily weights were up three pounds in a day or seven pounds in a day they would notify the provider. LPN-A accessed R20's medical chart and stated that it does look like R20 has an PRN order for metolazone that should be used is weight is up. During interview on 5/22/24 at 9:47 a.m., registered nurse care coordinator (RN)-B stated residents with daily weights has the weights obtained and if they have parameters and/or PRN medications to be utilized, licensed nursing staff should administer PRN medication and then notify provider of weight gain and PRN usage. RN-B confirmed R20 had an order for PRN Metolazone to be administered for increased weight gain. RN-B stated licensed nursing staff probably do not know that R20 has this order as it is not linked to the daily weight task. RN-B stated that in the daily weight task it should prompt licensed nursing staff that resident has a PRN order that can be utilized. RN-B stated this was important because it is a provider's order and should be followed. RN-B stated medication is important due to fluid retention due to his congestive heart failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/22//24 at 11:46 a.m., director of nursing (DON) stated she expected provider's orders to be followed with PRN medications. DON confirmed PRN medication should have been administered with the increased weight gain. DON stated this was important as R20 needs these monitoring/medications for his congestive heart failure and physician's orders need to be followed During interview on 5/22/24 at 12:38 p.m., consultant pharmacist (CP) stated metolazone should have been administered to R20 with the increased weight gain overnight. CP stated it is important to follow provider orders as they are ordered for management of congestive heart failure. On 5/22/24 at 2:07 p.m., call was placed to primary doctor with no return response. The facilities Medication Guidelines policy dated 5/24, indicated the facility would ensure the accurate storage and safe/effective administration of medications by qualified personnel. Medications are administered by qualified personnel who 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. Medication orders are to be administered as ordered by the provider.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on observation, interview and document review, the facility failed to perform hand hygiene after high contact direct cares for 1 of 3 residents (R114) reviewed for infection control. Findings include: R114's admission Minimum Data Set (MDS) and Care Area Assessment (CAA) dated 5/8/24, identified an admitted [DATE], moderately impaired cognition, diagnoses of end stage renal disease with need for hemodialysis, diabetes, and pressure ulcers. The MDS/CAA also identified R114 had a recent extensive hospital stay related to diabetic ketoacidosis and inflammation of the colon caused by the bacteria Clostridium difficile (C. Diff.), had frequent bowel incontinence, was very deconditioned and dependent for transfers and mobility. During observation on 5/20/24 at 12:29 p.m., a sign identifying the need for transmission-based precautions (TBP) was placed on the wall in the alcove outside R114's room with a cart of personal protective equipment (PPE). The sign specified contact enteric precautions (intended to prevent transmission of intestinal pathogens that are spread by direct or indirect contact with the resident or environment) and instructed staff to wash hands or use hand sanitizer, don gown and gloves prior to entry at the door and to wash hands upon leaving the room. During observation on 5/20/24 at 5:33 p.m., nursing assistant (NA)-B communicate the need for resident transfer assist via walkie, donned gloves and a gown then entered R114's room. NA-A arrived and donned gloves and gown and entered the room. NA-A and NA-B proceeded to assist R114 with sitting up in bed and then transferred her to the recliner using a sit to stand mechanical lift that was being stored in the resident bathroom. When finished NA-A doffed and disposed of her gown and gloves in the covered waste basket in R114's room near the door, opened the door and proceeded down the hall to the unit dining room, retrieved a meal tray off the kitchenette counter then walked back to R114's room and handed the tray to NA-B who was still in the room. No handwashing was observed after leaving R114's room. When interviewed on 5/20/24 at 5:41 p.m., NA-A stated she did not know why R114 required contact/enteric precautions and acknowledged she had not sanitized or washed her hands after assisting with R114's transfer but should have. NA-A stated usually staff could use the hand sanitizer when leaving a resident room until they could get to a nearby sink on the unit to wash their hands with soap and water. When interviewed on 5/22/24 at 7:46 a.m., registered nurse (RN)-A stated with residents on any type of infection precautions staff are informed of why and what control measure to take in shift-to-shift communications, through residents' electronic medical record and paper care sheets. RN-A stated hand sanitizer is available to use until staff can go to a sink to wash their hands with soap and water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/22/24 at 10:32 a.m., the director of nursing (DON) stated any need for TBP is tracked through the admission process and with any signs or symptoms of infection in residents and the licensed nurses can determine what type to implement then inform and communicate to other nursing staff. The DON stated all staff are educated on the importance of hand hygiene upon hire then routinely or as needed thereafter. The DON stated R114 was on contact enteric precautions related to C. Diff. diagnosis and a sign had been placed over the hand sanitizer dispenser in her room to wash hands with soap and water because hand sanitizer does not kill the C. Diff. organism. The DON stated routine hand washing by staff was important to protect residents and themselves from spreading infections. The facility policy Handwashing/Hand Hygiene dated 1/2023, identified the need for washing hands with soap and water after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. Diff.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on interview and document review, the facility failed to ensure 1 of the 5 residents (R55) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R55's significant change Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of hypertension, peripheral vascular disease and diabetes. R55's face sheet, dated 5/22/24, indicated he was [AGE] years old. The immunization record, dated 5/22/24, indicated he received a PPSV23 on 7/13/2017 and a PCV13 on 4/20/16. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R55 or representative was offered or received a PCV20. During an interview with the director of nursing (DON) who is also the infection preventionist (IP), on 5/22/24 at 10:32 a.m., the DON/IP indicated immunizations are verified upon admission through MIIC (Minnesota Immunization Information Connection) and resident medical records. The DON/IP stated residents and/or their representatives would be offered and educated on the risk/benefit of the PCV20, and consents are obtained if eligible. The DON/IP stated it is a collaboration for determining eligibility and administration of the vaccines including the facility pharmacy and resident providers. The DON/IP stated they follow their policies for immunization guidelines, and they are based on CDC recommendations. The DON/IP verified R55's pneumococcal immunizations as listed above. The DON/IP verified R55 had not been offered or provided education on PCV20. The facility policy Pneumococcal Immunization, Long Term Care dated 4/2024 identified Residents will be offered the pneumococcal vaccinations and administered, according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized, or the resident and/or the resident representative declines the vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on interview and document review, the facility failed to ensure education on benefits and potential side effects of COVID-19 booster vaccination and administration of the vaccination to 1 of 5 residents (R55) reviewed for COVID-19 vaccination status. Findings include: The most recent Centers for Disease Control (CDC) Covid-19 vaccine guidance dated 2/7/24, recommends everyone aged [AGE] years and older, including people who live in Long-Term Care (LTC) settings who received one dose of any updated 2023-2024 Covid -19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive one additional dose of an updated Covid-19 vaccine at least four months after the previous updated dose. R55's significant change Minimum Data Set (MDS) dated [DATE] indicated moderately impaired cognition and diagnoses of hypertension, peripheral vascular disease and diabetes. R55's face sheet indicated R31 had admitted to the facility on [DATE] and was [AGE] years old. R55's electronic medical record (EMAR) indicated he had last received a Covid-19 booster vaccination on 3/15/23. R55's lacked documentation of any additional COVID-19 booster vaccination and evidence of education regarding the benefits and potential side effects of additional COVID-19 booster vaccination. R55's EMR lacked evidence of any contraindication to Covid-19 vaccination. During an interview with the director of nursing (DON) who is also the infection preventionist (IP), on 5/22/24 at 10:32 a.m., the DON/IP indicated immunizations are verified upon admission through MIIC (Minnesota Immunization Information Connection) and resident medical records. The DON/IP stated residents and/or their representatives should be offered and educated on the risk/benefit of the Covid-19 booster, and consents are obtained if eligible. The DON/IP stated it is a collaboration for determining eligibility and administration of the vaccines including the facility pharmacy and resident providers. The DON/IP stated they follow their policies for immunization guidelines, and they are based on CDC recommendations. The DON stated this process was missed for R55. The facility policy Covid-19 Vaccine Policies and Procedures dated 10/2023, identified Covid-19 vaccinations will be offered to all staff and residents (or their representative if they cannot make health care decisions) unless such immunization is medically contraindicated, per CDC guidance, or the individual has already received all recommended doses.