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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Willmar	1801 Willmar Avenue Southwest Willmar, MN 56201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rights were maintained for 1 of 3 residents (R37) reviewed for dignity.Findings Include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R37's diagnoses included non-Alzheimer's dementia, weakness and localized edema. MDS also indicated R37 had an indwelling external catheter. During observation on 8/4/25 at 2:21 p.m., R37's urinary catheter drainage bag, which was approximately half full of dark amber colored liquid, was hanging on the left side of bed. Drainage bag was visible to all residents and staff who walked past. During observation on 8/5/25 at 2:19 p.m., R37's urinary catheter drainage bag, which was approximately one-quarter full of dark amber colored liquid, was hanging on the left side of bed. Drainage bag was visible to all residents and staff who walked past. During observation on 8/6/25 at 8:50 a.m., R37's urinary catheter drainage bag, which was approximately half full of dark amber colored liquid, was hanging on the left side of bed. Drainage bag was visible to all residents and staff who walked past. During observation on 8/7/25 at 7:46 a.m., R37's urinary catheter drainage bag was hanging on the left side of bed. Drainage bag was visible to all residents and staff who walked past. During interview on 8/6/25 at 1:30 p.m., nursing assistant (NA)-C stated if a resident had a catheter bag it should always be covered so others could not see it. NA-C confirmed R37's urinary catheter drainage bag was not covered and was visible to all. During interview on 8/7/25 at 7:55 a.m., trained medication assistant (TMA)-A stated if a resident had a urinary catheter the drainage bag should be covered at all times for the resident's dignity. During interview on 8/7/25 at 8:13 a.m., registered nurse (RN)-C stated the catheter drainage bag should be hung on the side that would be more private for the resident and the bag should always be covered with a catheter cover bag to respect the resident's privacy and dignity. During interview on 8/7/25 at 8:17 a.m., licensed practical nurse (LPN)-C stated catheter drainage bag should be hung on whatever side where tubing is attached to the resident. LPN-C stated it was important to ensure drainage bag is placed lower than the bladder and cover the bag so no one can see bag for the resident's privacy. During interview on 8/7/25 at 9:49 am., director of nursing (DON) stated she would expect staff to place and cover urinary catheter drainage bag so it was not visible as it could be a dignity concern for the resident. DON confirmed she had noticed R37's catheter bag not covered and visible from hallway earlier this week. The facility Quality of Life - Dignity policy, last reviewed 1/2024, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Resident shall be treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist resident as needed by helping the resident to keep urinary catheter bags covered.

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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to inform residents in the facility that all bird feeders, including personally owned bird feeders, were being removed, prior to doing so, for 1 of 1 residents (R34) in the sample. Findings include: In review of R34's electronic medical record diagnosis page, the following diagnoses were listed: Parkinson's disease, cerebral palsy, major depression with moderate recurrence, and anxiety disorder. R34's quarterly Minimum Data Set (MDS), dated [DATE], indicated resident required minimum - moderate assistance from staff for all activities of daily living. The MDS also indicated R34 was cognitively intact. A review of R34's assessments, the following was documented:6/20/25 Mood Interview (PHQ-9) R35 scored of 8 of 27 which indicated R35 was mildly depressed.6/20/25 Brief Interview for Mental Status (BIMS) R35 scored 15 out of 15 which indicated R35 was cognitively intact. R34's care plan printed 8/6/25, documented resident had been care planned for Mood / Psychosocial concerns with the following:Potential for adjustment concerns related to [long term care] placement. [Diagnoses of depression and anxiety. PHQ-9 score 8/27 on 6/20/25 indicating mild symptoms of depression/ [R34] loves all things cats and finds comfort with socializing with the household cat. {R34] dislikes the song Rocky Mountain High by [NAME] Denver as it reminds him of his dog when he was a child and requests that the song be changed when it plays in the dining room. During resident interview on 8/4/25 at 4:23 p.m., R34 and a family member (FAM)-A were sitting in his room visiting. R34 stated he was upset the facility had taken down his window bird feeders. R34 stated he has fed birds all his life and had actually built a bird feeder out of a bird cage, so that the black birds and squirrels could not get inside to take the food from the song birds. FAM-A interjected, R34's bird watching helped him with his anxiety and depression. It was something that he took pride in. As FAM-A was explaining how involved resident was with bird watching and bird feeding, R34 wiped his eyes with his shirt sleeve. R34 stated he was on an outing last week with his family. When he returned, he noticed the bird feeders were missing. R34 asked staff, who informed him corporate had informed the facility that all bird feeders (even the resident owned ones) were to be taken down due to a recommendation from the corporate contracted pest control provider. On 8/6/25 at 2:04 p.m., registered nurse (RN)-A stated staff heard the facility administrator had received a email from corporate which instructed [NAME] facilities were to remove all bird feeders from the properties. They were informed the pest control contractor (Plunkett's Pest Control) recommend this being done, for safety reasons of bird seeds on sidewalks, and pest mitigation. RN-A stated she was not aware rodents were an issue within the building. During interview on 8/6/25 at 3:59 p.m., the administrator and corporate RN (CorpRN) stated last week an email came from corporate to all facility administrators, to remove all bird feeds from their property, including ones hung by the residents/families themselves. Corporate was concerned about bird seed on sidewalks being a safety concern, as well as, the increased potential for rodent infestations. The administrator stated she requested the maintenance department remove all bird feeders on the property. Administrator didn't think about informing residents, while she thought all the bird feeders were facility owned. During a further interview on 8/7/25 at 9:47 a.m., CorpRN stated he had a telephone conversation with the corporate owner this morning. CorpRN verified the recommendation came from corporate, from the recommendation of the pest control provider, for the prevention of rodent infestation, and all administrators were informed to remove bird feeders from all facility properties. The facility was unaware R34's bird feeders were privately own when removed. CorpRN stated he would be meeting with R34 today to see if there is an acceptable alternate bird feeding system the facility could provide. The facility did not have policies for when facility systems / processes are changed which may directly impact residents.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete and implement a baseline care plan within 48 hours of admission for 1 of 2 residents (R22) reviewed for care plans.Findings include: R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R22's diagnoses included: Type II diabetes mellitus with diabetic chronic kidney disease, heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), hypertension (high blood pressure), hemiplegia (a condition characterized by weakness or paralysis on one side of the body), malnutrition (a serious condition resulting from an imbalance in nutrient intake, leading to deficiencies or excesses that negatively impact health), depression, dependence on renal dialysis and hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream). MDS indicated R22 received dialysis services and was on a therapeutic diet. R22's electronic health record (EHR) indicated R22 was admitted to the facility on 12/2024. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 12/26/24 and indicated R22 was dependent on staff for transfers, toileting and grooming/bathing. During interview on 8/7/25 at 10:31 a.m., director of nursing (DON) stated baseline care plans should be completed within 48 hours of admission to the facility. DON confirmed a baseline care plan had not been completed with 48 hours of admission for R22. RN-A stated baseline care plans are important to complete for resident safety and so staff know how to care for the resident. The facility Baseline Care Plan facility, dated 11/21, indicated facility would develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a wheeled walker was not used as a wheelchair for 1 of 1 residents (R10) which placed resident at increased risk for a fall. Findings include: R10's quarterly minimum data set (MDS) dated [DATE], indicated R10 was cognitively intact and was independent with cares. R10s care plan dated 12/3/24, indicated R10 was up ad lib (allowed to get out of bed and move around as they please, without restrictions), ambulated and transferred slow and steady with four wheeled walker, and R10 was at risk for falls related to decreased functional strength, decreased activity tolerance and impaired standing balance. On 8/04/2025, at 10:57 a.m. was observed sitting on four wheeled walker using feet to propel walker backwards, two wheeled legs were observed to be bowed outwards from the walker. There was no wheelchair observed in R10s room. On 8/04/2025 at 11:30 a.m., R10 was observed entering the building sitting on four wheeled walker, propelled backward using feet. When interviewed on 8/07/2025 at 8:04 a.m., R10 stated no facility staff had spoken with him regarding potential risks related to using wheeled walker as a wheelchair. R10 stated he did not have a wheelchair and prior to admission to the facility he had a fall from the walker while propelling it backwards down a sidewalk, had hit head on the sidewalk after the walker had hit a bump and flipped out from under him. When interviewed on 8/07/2025 at 8:20 a.m., nursing assistant (NA)-B stated R10 normally used the walker as a seat and propelled backwards. NA-B stated R10 was told the wheels were flared out due to weight and was not safe to use. When interviewed on 8/07/2025 at 8:39 a.m., registered nurse (RN)-B stated R10 walked short distances when in room, when outside of room propelled walker backwards instead of using a wheelchair. RN-B stated R10 was informed sitting on the walker while propelled backwards was not safe, however, R10 continued to use the walker in that manner. When interviewed on 8/07/2025, at 9:56 a.m. director of nursing (DON) stated many things could happen to R10 when walker was used as a wheelchair, the walker could roll away or collapse, R10 or anyone that used a walker inappropriately was at an increased risk for a fall. DON stated R10 was bigger in size, would think the wheels would be bowed out. DON identified there was no risk/benefits located in R10's electronic record, nor was there a referral to therapy to ensure R10 had a proper and safe mobility device. Facility policy regarding resident safety and mobility devices was requested, however, none was received.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure coordination of dialysis care for 2 of 2 resident (R3 and R22) who required dialysis (treatment to filter blood when kidneys are no longer able). Additionally, the facility failed to ensure post-dialysis assessment and monitoring was completed for 2 of 2 resident (R3 and R22) reviewed for dialysis.Findings include: R3 R3's 5-day Minimum Data Set (MDS) dated [DATE], identified R3 had intact cognition and required assistance with all activities of daily living (ADL)'s. R3's diagnoses included heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), hypertension (high blood pressure), renal failure (occurs when the kidneys are unable to adequately filter waste and excess fluid from the blood), diabetes mellitus (a metabolic disease where blood glucose levels are too high due to the body's inability to produce enough or properly use insulin), malnutrition (a serious condition resulting from an imbalance in nutrient intake, leading to deficiencies or excesses that negatively impact health), chronic obstructive pulmonary disorder (a progressive lung disease that makes it hard to breathe), dependence on renal dialysis and acquired absence of right leg below knee. R3's provider order printed 8/6/25, indicated R3 had dialysis treatments every Monday, Wednesday, and Friday. R3's electronic health record (EHR) identified R3 went to dialysis eleven times since admission with only two communication forms sent with. The facility's top portion of the communication form was not completed. Information on communication form to be completed by facility included:Resident NameDatedate of birth Code StatusMental StatusAccess Site LocationAccess TypeAccess Site BleedingSigns of InfectionMedications given pre-dialysis: Please not any pain meds or BP medsDiet/Fluid RestrictionVitals signs (temperature, pulse, respirations and blood pressure)New medications since last treatmentChange in medical condition since last treatmentAdditional commentsLTC Nurse signature with date R3's medical record lacked documentation of monitoring of shunt for bruit and thrill (bruit is an abnormal, swishing sound heard through a stethoscope, while a thrill is a palpable vibration felt over the same area. Both are associated with turbulent blood flow, often indicating a narrowing or other abnormality in a blood vessel). R3's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for reviewed dates 7/8/25 - 8/6/25 lacked directions for staff to check for bruit and thrill. In addition, MAR and TAR lacked evidence of monitoring of shunt for bruit and thrill. R22 R22's quarterly MDS dated [DATE], identified R22 had moderate cognitive impairment and required assistance with all ADL's. R22's diagnoses included: Type II diabetes mellitus with diabetic chronic kidney disease, heart failure, hypertension, hemiplegia (a condition characterized by weakness or paralysis on one side of the body), malnutrition, depression, dependence on renal dialysis and hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream). MDS indicated R22 received dialysis services and was on a therapeutic diet. R22's provider order printed 8/6/25, indicated R22 had dialysis treatments every Monday and Friday. R22's EHR identified. R22 went to dialysis 26 times since 5/12/25, only 10 communication forms were sent with. Eight Communication forms indicated facility's top portion of form was empty and not completed with two being completed fully. Information on communication form to be completed by facility included:Resident NameDatedate of birth Code StatusMental StatusAccess Site LocationAccess TypeAccess Site BleedingSigns of InfectionMedications given pre-dialysis: Please not any pain meds or BP medsDiet/Fluid RestrictionVitals signs (temperature, pulse, respirations and blood pressure)New medications since last treatmentChange in medical condition since last treatmentAdditional commentsLTC Nurse signature with date R22's medical record lacked documentation of monitoring of shunt for bruit and thrill. R22's MAR and TAR for reviewed dates of 6/1/25 - 8/6/25 lacked directions for staff to check for bruit and thrill. In addition, MAR and TAR lacked evidence of monitoring of shunt for bruit and thrill. During interview on 8/6/25 at 3:30 p.m., registered nurse (RN)-D stated communication forms are (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to be sent back and forth to dialysis with the resident to communicate status and if there were any changes. RN-D stated she would expect the facility to complete the entire top section of the communication form, so they are aware of what is going on with the resident. RN-D stated the dialysis clinic would complete the bottom portion of the form to return to the facility with information regarding their dialysis run. If there were any pertinent changes the dialysis clinic would also call the facility and communicate the changes. RN-D stated both R3 and R22 had a fistula and would expect the facility to check for bruit and thrill. During interview on 8/7/25 at 8:17 a.m., licensed practical nurse (LPN)-A stated communication forms are expected to have the top portion completely filled out and sent with to the dialysis center. LPN-A stated communication forms should contain vital signs, diet, any medications changes or as needed medications received, dialysis port location, mental status, code status and any changes in resident's condition. LPN-A stated the monitoring for dialysis residents consisted of monitoring fluid restrictions, assess for redness or signs of infection at the port site and if the resident had increased edema. During interview on 8/7/25 at 9:35 a.m., LPN-B stated on resident's dialysis days a communication form was completed with resident's vitals, weight, medications, port location and any changes in condition and is sent with the resident to the dialysis clinic. Dialysis clinic would then complete the bottom portion of the form and return it to the facility. LPN-B stated R3 and R22 had fistulas and monitoring should include checking fistula for bruit and thrill. LPN-B stated she checked for bruit and thrill but does not document it anywhere as it is not on the MAR/TAR. During interview on 8/7/25 at 9:50 a.m., director of nursing (DON) stated the documentation regarding dialysis had been lacking. DON confirmed R3 only had two communication forms sent with that were not completed by the facility and R22 had 10 communication forms sent with eight of them not completed. DON stated the communication forms are important so there was communication between the facility and the dialysis clinic. DON stated she expected the top of the communication form to be completely filled out. DON stated she expected nursing to be monitoring the fistula site for bruit and thrill. DON stated it was important to ensure the fistula was patent and not infected especially when they return from dialysis. DON confirmed there is no monitoring for bruit and thrill in place for neither R3 or R22 but should be. The facility Hemodialysis, Care of a Resident policy, dated 8/25, indicated the facility will ensure that residents who require dialysis receive such services, consistent with professional standards of practice. - Licensed Nursing Staff will provide ongoing assessment of the resident condition and monitoring for complications after dialysis treatments received at a certified dialysis facility. - Licensed staff will monitor for complications related to post-hemodialysis which may include, but are not limited to:o Bleedingo Leg crampso Seizureso Nausea/vomitingo Unsteady [NAME] Headacheo Fatigueo Signs/symptoms of infectiono Hypotensiono Chest pain- The Charge Nurse will be responsible for ongoing communication with the dialysis facility including the following:o Sending current physician orders, lab reports, and vital signs to dialysis facility.o Advance Directives and code status; and any changes or need for further discussion with the resident/representative, and practitioners.o Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.o The identification of symptoms such as anxiety, depression, confusion, and/or behavioral symptoms that interfere with treatments.o Dialysis adverse reactions/complications, and/or concerns related to the vascular access site/PD catheter.o Changes and/or decline in condition unrelated to dialysis. This would include communication related to care concerns such as a resident who is at risk for or who has a pressure ulcer, receiving appropriate interventions; [NAME] The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility.

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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** Based on interview and document review, the facility failed to ensure tuberculosis (TB) testing was completed for 1 of 6 sampled residents (R68) reviewed for required baseline TB screening and testing. Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis (TB) in Health Care Settings, 2005, directed all residents and staff must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. R68's Minimum Data Set (MDS) entry tracking record dated 7/11/25, indicated he initially admitted to the facility on 7/2025. An initial baseline TB screening for signs and symptoms was completed 7/11/25, however R68'S electronic medical record (EMR) lack evidence of testing for the presence of TB infection. During interview on 8/5/25 at 1:12 p.m., the director of nursing (DON) stated all new residents were screened for TB and would be administered the first step tuberculin skin test (TST) upon admission or within 72 hours of admission. The DON stated the timeline from the administration to the reading of the results was 48 to 72 hours after administration. The DON stated TST's must be read during that period of time to ensure accuracy. The DON confirmed R68 did not receive the 1st TST before being re-hospitalized on [DATE]. The DON stated it was important to make sure resident TST's were administered and read within the timeframe of 48 to 72 hours with the second step occurring seven to 21 days after step one to verify resident's tuberculosis status and that it is accurate. The facility's Tuberculosis, screening residents policy dated 2025, indicated for all new admissions or re-admissions, residents would screened for TB infection in compliance with state regulations which includes the first step TST being performed within 72 hours of admission and read by a licensed nurse within 48-72 hours after administration. If the first step is negative, the second TST would be administered one to three weeks from date first step was read and be read by a licensed nurse within 48-72 hours after administration.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the nursing staff posting (which included number of nurses and nursing assistants and the hours they were scheduled) was posted and available for all residents. families and visitors. This potentially effected all 20 residents residing in [NAME] House, all 20 residents residing in [NAME] House and their families / visitors. Findings include - Upon entering the facility on Monday 8/4/25 at 10:30 a.m., the survey team noted the posting of the Resident Rights and facility's survey results. However, in the front entrance of the facility, and in both front wings of the facility (Long Term Care units - [NAME] Cottage and [NAME] House) the lacked evidence the facility had posted the required staff posting of hours and nursing staff scheduled. After the initial walk through of the facility (on 8/4/25), the surveyors on the Transitional Care Unit (TCU - units 100 and 200) were unable to locate the posting as well. The long Term care (LTC) unit is separated from the TCU by means of a wing which included the administrative offices and therapy department. and one needed to walk through a set of closed fire doors to go between the two sections / levels of care. The survey team continued to observed for the postings, from 8/4/25 - 8/7/25. However, on 8/7/25 at 7:56 a.m., a surveyor on 100 unit noted the staff posting on a hallway wall dated 8/6/25 (the day prior), and was posted in an acrylic frame that was posted sideways. To read the posting, one would either have to take the posting out, or turn their head sideways to read the posting. During interview on 8/07/2025 at 11:17 a.m., the facility administrator verified the staff posting should be both on the TCU and the LTC units. Administrator stated the posting for the LTC wings should be on the receptionist desk, in that general area at the main entrance. The administrator stated the staff person responsible is currently on family medical leave, and the reassignment of that task had been over looked. The administrator stated she would have maintenance rehang and straighten the acrylic holder on the TCU.