



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2026

Administrator
CURA OF WILLMAR
1801 WILLMAR AVENUE SOUTHWEST
WILLMAR, MN 56201

RE: CCN:245410
Cycle Start Date: July 15, 2026

Dear Administrator:

On July 15, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

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 October 15, 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 January 15, 2027 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245410		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER CURA OF WILLMAR				STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WILLMAR AVENUE SOUTHWEST , WILLMAR, Minnesota, 56201			
(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
E0000	Initial Comments On 7/13/26 to 7/15/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			07/31/2026
F0000	INITIAL COMMENTS On 7/13/26 to 7/15/26, a standard recertification survey S5410042-0 was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54102537C (3010372),H54103245C (2799183), H54103244C (2962390), H54103243C (3008423), H54103242C (3024848). NO deficiencies were cited. The following complaints were reviewed: H54103246C (2640905) with deficiencies cited at F686. 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 substantial compliance with the regulations			F0000			

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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F0000	Continued from page 1 has been attained.			F0000			07/31/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 2 residents (R29) reviewed for pressure ulcers. Findings Include: R29's quarterly Minimum Data Set (MDS) dated 6/16/26, identified R29 was cognitively intact and had diagnosis which included; diabetes mellitus, coronary artery disease, and hypertension. R29's MDS identified R29 was dependent for dressing lower half, transfer, toileting and required substantial/maximal assistance with rolling in bed side to side. R29 had one stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or with directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). R29's Care Area Assessment (CAAS) dated 12/19/25, identified R29 had alteration in skin integrity due to being admitted with chronic pressure ulcers and diabetic foot ulcers. R29's CAAS identified R29 was often noncompliant with repositioning and often refused to get out of bed. R29's Braden Scale For Predicting Pressure Sore Risk assessment dated 6/16/26, identified R29 was at moderate risk for pressure ulcers with a score of 13. R29's Tissue Tolerance Lying assessment dated 12/16/25, identified length of observation time was two hours. The assessment identified R29 had exsisting wounds to heels and coccyx, and based on observations R29 should be			F0686	Date of Completion: 8/07/2026 Date of Survey: 7/13/2026-7/15/2026 Tag Number / Description: F0686- Pressure Ulcer and Skin Integrity Regulatory requirements: A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards and practice, to promote healing, prevent infection and prevent new ulcers from developing. Description of how the requirement was not met: Requirement not met as evidenced by: Failure to ensure timely assistance with repositioning occurred for 1 of 2 residents (R29) reviewed for pressure ulcers. Drafted plan of correction: Resident R29 was repositioned immediately upon surveyor informing staff. The facility will complete an audit resident care plans to assure that interventions for repositioning based on the resident assessment and that residents are subsequently assisted with repositioning timely. Nursing staff will be provided re-education on the facility policy "Skin Integrity Maintenance and Pressure Injury Prevention, Long Term Care" and on the need to reposition residents timely in alignment with their plan of care. The Director of nursing and/or designee will completed observational audits to assure residents are being assisted with repositioning timely in accordance with the plan of care. Audits will be performed three times a week for two weeks, then two times a week for two weeks, then once a week for two weeks then monthly until the next Quality Assurance Committee meeting at which time audit results will be reported to and reviewed to ensure sustained compliance.		08/07/2026

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F0686 SS = D	Continued from page 2 repositioned every two hours. R29's Wound Observation Tool dated 7/15/26, identified R29 had a stage 4 pressure ulcer on his coccyx, 2 centimeters (cm) lenght, 1 cm width and 3 cm depth. Summary identified wound stable, no change. No signs or symptoms of infection, with a small amount of serosanguineous drainage. Surrounding (peri) wound skin intact and within normal limits. R29's care plan revised 6/11/26, identifed R29 had alteration in skin integrity related to chronic pressure ulcer and diabetic foot ulcer. Interventions included air pressure mattress, nutritional supplements, and turn and repostion per tissue tolerance. R29's Visual Bedside Kardex Report dated 7/15/26, identified R29 was independent to make minor position changes but for turns and boosts up in bed required two assistance with lift sheet. Able to use trapeze (triangle bar above bed) independently. R29 unable to reposition self in bed, needed frequent encouragement to reposition due to wounds. Assistance of two to boost up in bed and assist to turn over in bed. May use trapeze to assist with bed mobility. R29s Kardex lacked instructions for how often to reposition R29. During continuous observation on 7/14/26 at 7:06 a.m to 9:51 a.m., identified the following: -7:06 a.m., R29 lying in bed on back, pillows on sides and under lower legs, head of bed slightly elevated. R29 was drinking water. R29 indicated his wound care was completed earlier that morning. -7:18 a.m., staff member entered R29's room with breakfast tray, then left room. -7:19 a.m., hospital staff member outside of R29's door, then left area. -7:20 a.m., facility staff member returned with a glass of milk she provided to R29. The hospital staff member entered R29's room to complete lab work. -7:26 a.m., hospital staff member left R29's room. -7:52 a.m., staff member entered R29's room and asked if could remove breakfast tray. Staff member obtained two containers of pudding out of R29's refridgerator, and placed on bedside table as requested, then left R29's room with breakfast tray. -7:52 a.m., a staff member entered room and asked if needed anything as R29's call light was on. R29 asked when could get pain medication, and staff member stated would inform nurse, sanitized hands, then left room. R29 remained in same position.			F0686			08/07/2026

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F0686 SS = D	Continued from page 3 -8:17 a.m., nurse in hallway with medication cart leaving area, staff member walked by stating "daily chronical" then entered R29's room. Staff member sat down in chair next to bed and began to read and visit with R29. -8:40 a.m. staff member left R29's room. R29 remained in same position. R29 held a paper in hand and appeared to be reading it. -8:58 a.m., R29 remained in same position. No staff members near R29's room. -9:07 a.m., R29 remained in same position, while looking out window. No staff members near R29's room. -9:31 a.m. R29 remained in same position, while on phone. No staff members near R29's room. -9:32 a.m. activity assistant (AA)-A entered R29's room and brought snacks. AA-A straightened R29's room asked about daily chronicels and appointment, then sat down in chair and began visiting. R29 remained in same position. -9:51 a.m. AA-A continued to sit in chair in R29's room visiting. R29 remained in same position. At no time during continouous observation did any staff offer to reposition R29. During observation on 7/15/26 at 9:54 a.m. surveyor informed clinical manager registered nurse (RN)-A that R29 had not been repositioned as care planned. At 9:56 a.m. RN-A went to R29's room and donned a gown and gloves. Assistant director of nursing (ADON) joined RN-A outside R29's room and donned gown and gloves then both entered R29's room. RN-A asked R29 if they could check his skin, and R29 agreed. ADON and RN-A removed pillows from both sides of R29, and two pillows from under R29's lower legs and assisted R29 to turn onto his right side. RN-A proceeded to perform incontinence cares for R29. RN-A confirmed R29's left buttocks and upper thigh was red in color, but blanchable. RN-A removed R29's socks and boots, checked R29's heels, then replaced the slipper socks and blue heel protection boots. No redness on heels were noted. ADON and RN-A proceeded with cares, then assisted R29 to return to previous position with a pillow on each of his sides of buttocks and trunk, and a pillow under each lower leg. During interview on 7/15/26 at 10:45 a.m., nursing assistant (NA)-C verified was working on R29's wing with NA-D. NA-C stated had not assisted R29 earlier that morning. NA-C indicated usual practice was to assist R29 with repositioning every 2-3 hours. NA-C indicated R29 did not like to be repositioned and liked two pillows under his bottom and legs. NA-C stated she thought R29 may be able to offload			F0686			08/07/2026

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F0686 SS = D	Continued from page 4 himself with use of trapeze as she had seen him use it while repositioning him, but was not certain. During interview on 7/15/26 at 10:50 a.m., RN-A confirmed R29's last tissue tolerance assessment indicated to reposition R29 every two hours. RN-A stated R29 could offload his upper body, but was not sure of his lower body. RN-A indicated it was important to reposition R29 for skin integrity and get the pressure off. RN-A stated R29 wanted to be returned to the same position after cares completed with the use of the pillows. During interview on 7/15/26 at 11:06 a.m., director of nursing (DON) indicated she had been informed of R29 not being repositioned timely and confirmed R29's tissue tolerance assessment instructed staff to reposition R29 every two hours. DON stated that was important because R29 was bed bound, for his skin integrity and to prevent R29's pressure ulcer from worsening. DON indicated they would educate on the proper way to complete a tissue tolerance, because it was stopped at two hours, and R29 may have been able to be repositioned less often. DON also indicated staff needed education to check on R29 and reposition him following care plan. During interview on 7/15/26 at 12:04 a.m., NA-D verified that morning she had assisted R29 with morning cares and repositioning shortly after 6:00 a.m., as he was the first person who liked cares at that time. NA-D indicated R29 now could assist them with turning onto one of his sides. NA-D stated they had pillows to support him and he had an air pressure mattress on his bed. The facility policy titled Pressure Ulcers/Injuries Overview dated 4/24, identified the purpose of the procedure was to provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors. The policy referenced definitions from the MDS Resident Assessment Instrument User's Manual. The policy identified pressure ulcers/injuries occurred as a result of intense and/or prolonged pressure or pressure in combination with shear. The policy lacked interventions for care and prevention of pressure ulcers.			F0686			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			F0689	Date of Completion: 8/07/2026 Date of Survey: 7/13/2026-7/15/2026 Tag Number / Description: F0689- Free of Accident Hazards/Supervision/Devices Regulatory requirements: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance		08/07/2026

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F0689 SS = D	Continued from page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement care planned interventions to prevent further falls for 1 of 2 resident (R22) reviewed for falls. Findings include: R22 quarterly Minimum Data Set (MDS) dated 6/9/26, identified R22 had moderate impaired cognition, had diagnosis which included cancer, non-Alzheimer’s dementia. R22 required extensive assistance with activities of daily living (ADL’s) which included toileting, transfers, and locomotion. R22 had one fall with no injury since the last required assessment. R22 quarterly Care Area Assessments (CAA) dated 05/22/2026, identified R22 had a terminal condition due to cancer, had hearing or vision impairment, and was on hospice care. The CAA indicated R22 was an increased risk for falls. Review of R22's current care plan revised 12/24/26, showed R22 was a fall risk. Care plan indicated R22 was at high risk for falls related to de-conditioning, cognitive deficits and history of falls prior to admission. R22's care plan listed various fall interventions which included anti-rollbacks placed on the back of wheelchair to prevent tipping, encourage resident to wear appropriate footwear/shoes. Ensure resident has wheelchair behind him when ambulating in case resident is weak so he can sit, remove mobile bedside table and place a non-movable bed side table next to bed for tripping prevention. R22's fall risk assessment dated 5/22/26, identified R22 was at risk for falls. Review of R22's most recent post fall assessment dated 6/27/26, identified new interventions to try: Reviewed current fall prevention interventions. Re-established the intervention to remove the resident's mobile bedside table, as it was not clearly visible in commonly referenced documentation by staff.			F0689	Continued from page 5 devices to prevent accidents. Description of how the requirement was not met: Requirement not met as evidence by: Failed to implement care planned interventions to prevent further falls for 1 of 2 residents (R22) reviewed for falls. Drafted plan of correction: Mobile bedside table was removed from R22’s room upon being informed by surveyor that it was at resident's bedside. The facility will complete an audit of resident fall interventions to assure that current fall care plan interventions are in place. Re-education will be completed with nursing staff regarding reviewing the facility policy on “Fall Management – Long Term Care” including identifying, implementing and communicating resident fall interventions. The Director of Nursing and/or designee will complete audits of resident fall interventions to ensure that resident care planned fall interventions are implemented. Audits will be performed two times a week for two weeks, then once a week for four weeks then monthly until the next Quality Assurance Committee meeting at which time audit results will be reported to and reviewed to ensure sustained compliance.		08/07/2026

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F0689 SS = D	Continued from page 6 Review of R22's progress notes dated 6/27/26 at 02:52 P.M., R22 was calling out for help when staff followed the noise, staff observed R22 on the floor by room 416 doorway, resting on L elbow and feet facing forward, mobile bedside table in hallway next to R22. R22 was asked what he was doing with his bedside table, he indicated he was using it as walker. R22 stated " I was going to my room, " when asked how he fell. During an observation on 07/13/2026 at 2:13 P.M., R22 was in bed with mobile bedside table alongside bed. During an observation on 07/14/2026 at 8:56 A.M., R22 was in bed with mobile bedside table alongside bed. During an observation on 07/14/2026 at 9:01 A.M., Staff was in R22's room with mobile bedside table alongside bed. Staff did not remove bedside table when they exited the room. During an interview on 07/14/2026 at 9:23 A.M., nursing assistant (NA)-A reported she was unaware of any fall preventions that are currently in place for R22. NA-A stated they use Tasks function on computer charting for specific tasks that need to be completed for R22. NA-A verified table along R22's bedside was movable. During an Interview on 07/14/2026 9:31 A.M., licensed practical nurse (LPN)-A verified mobile bedside table is alongside bed and is movable. LPN-A reports that mobile bedside table is present to facilitate meals that R22 eats in room. LPN-A stated R22's care plan stated Movable table was not to be at bedside but thought that it should be reassessed. At 07/14/2026 9:46 A.M., NA-A stated she verified on R22's care plan the mobile bedside table is not to be at bedside and removed bedside table from R22's room. During an interview on 07/15/2026 at 9:52 A.M., Director of Nursing (DON) reported they spoke with staff and confirmed mobile table was bedside on			F0689			08/07/2026

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F0689 SS = D	Continued from page 7 7/14/26, and was removed after surveyor talked with staff. DON confirmed it is important to follow the care plan for patient and staff safety. DON confirmed residents have individualized care plans in order provide customized care for each resident. Review of a facility policy titled Fall Management - Long Term Care revised 6/2025, identified the facility assessed residents upon admission, after a significant change in condition and annually for falls and promptly began a falls prevention plan. Policy indicated a post-fall analysis was done after each fall and appropriate care planned interventions were to be followed.			F0689			
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observations, and document review, the facility failed to provide nursing rehab services as ordered for 1 of 1 resident (R44) reviewed for rehab services. R44's Quarterly Minimum Data Set (MDS) dated 4/20/26, indicated R44 had intact cognition, did not reject care that is necessary to achieve the resident's goals for health and well-being. R44's diagnoses included hemiplegia (left side weakness), hypertension (high blood pressure), and			F0825	Date of Completion: 8/07/2026 Date of Survey: 7/13/2026-7/15/2026 Tag Number / Description: F0825- Provide/Obtain Specialized Rehab Services Regulatory requirements: Provide the required services; or obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Description of how the requirement was not met: Requirement not met as evidence by: Failed to provide nursing rehab services as ordered for 1 of 1 resident (R44) reviewed for rehab services. Drafted plan of correction: R44 will receive nursing rehab services as identified in their plan of care. An audit will be completed of resident's identified with a plan of care for nursing rehab services to assure they are receiving the services as care planned. Re-education with nursing staff regarding the facility policy on "Nursing Rehab Services" including the need to complete care planned services timely, as well as the expectation to appropriately communicate any time it is refused and/or not able to be		08/07/2026

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F0825 SS = D	Continued from page 8 diabetes. R44's care plan revised on 6/10/26, directing staff to the nursing rehab program as noted in tasks; the program is overseen by a nurse and periodically reviewed. R44's discharge recommendations, signed 11/26/25, identified range of motion program; skilled physical therapy was necessary to develop a passive range of motion (PROM) program with staff to maintain range of motion (ROM) in left upper extremity and lower left extremity due to patients dependent status with transfers and mobility. Prognosis: good with consistent staff flow through. R44's Rehab Follow-Up Recommendations, signed 2/11/26, identified an order from physical therapy for a maintenance program three times a week; maintenance program directions were to set R44 up with self-range of motion, provide R44 with a seven-pound dumbbell three times a week to continue and maintain strength. A passive range of motion and stretching program was attached to identifying staff to communicate with patients on intensity of stretch, being gentle, and move slow. Stretches could be held for 30 seconds and repeated two to three times. Then move through movements five to eight times, slowly. Directions were attached for left arm elbow straightening, below bending, forearm, hand opening, and arm overhead stretching. Left leg and left knee left hip stretching. R44's task tab dated 2/11/26, identified nursing rehab to set patient up with self-ROM handout three times a week and assist as needed. R44's task tab dated 6/10/26, identified nursing rehab to provide patient with power web flex gripper and/or seven-pound dumbbell three times a week to continue and maintain strength. R44's task tab dated 6/10/26, identified nursing rehab to provide patient with power web flex gripper and/or seven-pound dumbbell three times a week to continue and maintain strength. R44's Documentation Survey Report dated July 2026, identified web flex gripper and/or seven-pound dumbbell exercises were completed:-two out of three times in the first week of July,-two out of three times in the second week of July.R44 ROM was completed:-two out of three times in the first week of July,-one out of three times in the second week of July. R44's Documentation Survey Report dated June 2026, identified web flex gripper and/or seven-pound dumbbell exercises were completed:-two out of three times in the first week of June,-two out of three times in the second week of June,-two out of three times in the third week of June,-once out of three times in the fourth week of June .R44's ROM was completed:-two out of three times in the first week of June,-two out of three times in the second week of June,-zero out of three times in the third			F0825	Continued from page 8 completed and the reason why to allow for appropriate review and response. The Director of Nursing and/or designee will complete audits to assure residents receive nursing rehab services according to their plan of care. Audits will be performed three times a week for two weeks, then two times a week for two weeks, then once a week for two weeks then monthly until the next Quality Assurance Committee meeting at which time audit results will be reported to and reviewed to ensure sustained compliance.		08/07/2026

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F0825 SS = D	Continued from page 9 week of June,-two out out three times in the fourth week of June. R44's Documentation Survey Report dated May 2026, identified web flex gripper and/or seven-pound dumbbell exercises were completed:-two out of three times the third week of May,-one out of three times the fourth week of MayR44 ROM was completed:-one out of three times the third week of May,-one out of three times the fourth week of May. R44's Documentation Survey Report dated April 2026, identified web flex gripper and/or seven-pound dumbbell exercises were completed:-one out of three times the first week of April,-two out of three times the third week of April,R44's ROM was completed:-two out of three times the first week of April,-one out of three times the third week of April, R44's Documentation Survey Report dated March 2026, identified web flex gripper and/ or seven-pound dumbbell exercises were completed:-one out of three times the first week of March,-zero out of three times the second week of March,-two out of three times the fourth week of March.R44 ROM was not completed:-one out of three times the first week of March,-one out of three times the third week of March-one out of three times the fourth week of March. R44's Documentation Survey Report dated February 2026, identified a web flex gripper and/or seven-pound dumbbell exercise program started on 2/11/26 and was completed:-one out of three times the third week,-zero out of three times the fourth week.R44 ROM was completed:-two out of three times the third week,-one out of three times the fourth week. During an interview on 7/13/26 at 12:06 p.m., R44 indicated R44 requested an order for rehab, and the restorative nursing aide comes to work R44's arms as he didn't want to lose strength in his right arm or ROM in his left arm. R44 indicated ROM and strength exercises occur once a week and believes it's ordered more often than once a week. During an interview on 7/14/26 at 4:32 p.m., registered nurse clinical coordinator (RNCC) indicated that when the restorative nursing assistant (RNA) is not working, the trained medical assistant (TMA) will complete the restorative program for the residents. RNCC was unaware who was to finish restorative programs if the RNA was unable to see all the residents in a given day. RNCC was not aware the RNA was having difficulties completing the restorative program for all the residents. During an interview on 7/14/26 at 5:29 p.m., RNA indicated R44 had a ROM program on his left arm and leg, which is done in his room, and then R44 goes to the therapy room for the dumbbell exercise on his right arm three times a week, Monday, Wednesday, and Friday. R44 has stayed in bed in the past or had refused to get out of bed. If he refuses, then it would			F0825			08/07/2026

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F0825 SS = D	Continued from page 10 be documented in the restorative progress notes as refused or on the tasks as refused. If R44 is at an appointment, it would be documented as n/a in the task charting area. RNA indicated she was the only RNA and was unsure who covers the restorative program when she is gone. RNA indicated at one time there were two RNA's but has been doing the restorative programs by herself the past two years and feels like she is seeing more people than before. RNA indicated she is responsible for the whole building restorative programs and at times is unable to see all the residents on a restorative program each day depending on the time a resident wakes up, appointments, and activities a resident might be at. These things would impacts if they are seen or not. RNA indicated her normal practice was to let the nursing assistants (NA) know who was not seen. RNA indicated other nursing aides can do ROM but not the exercises in the physical therapy room. RNA indicated the nursing assistants can chart ROM but is unsure if all the NAs were aware that they can chart or were able to complete ROM after she leaves for the day. RNA was not aware if anyone was assigned to do restorative when she takes time off. RNA indicated she had informed the previous administrator, physical therapist, and director of nursing that she does not have enough time to see everyone depending on the daily schedule. RNA charting was shown from the previous month and the blank areas. RNA indicated she had time off the previous month; other blank days R44 might have refused, and RNA didn't have time to chart the refusals. RNA has not noticed a decline in R44 strength for ROM, but if there was a decline, she would relay that information to therapy, and they would ask the doctor for orders to evaluate R44. During an interview on 7/15/26 at 9:06 a.m., NA-B indicated training was not received regarding restorative programs. NA-B indicated training had been done with helping with walking and the exercise bike. During an interview on 7/15/26 at 11:07 a.m., TMA indicated she used to work part time as a restorative nursing aid and would do one hallway and the RNA would complete the other hallway, but was told she was no longer needed. Unsure who was to cover for RNA when she is off. TMA indicated when RNA leaves, and there is ROM to be completed, the charting tab would have to be switched over to chart in the tasks. TMA is unsure if NA's were aware of how to switch this tab or if all the NAs have access to chart under the restorative program. TMA was aware of R44 having a restorative program but was unsure what the program was without having to look in the chart. TMA had not noticed ROM or strength decreasing. During an interview on 7/15/26 at 10:01, certified occupational			F0825			08/07/2026

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F0825 SS = D	Continued from page 11 therapy assistant (COTA) indicated therapy does not oversee the restorative nursing assistant and was not aware of what her caseload was. COTA indicated nursing was to oversee the RNA. COTA indicated there were two RNA's in the past, but now there is one RNA. COTA was unsure if the nursing assistants were trained in ROM. COTA indicated therapy does not currently see R44 and is unaware if there has been a decrease in ROM. During an interview on 7/15/26 at 10:05 a.m., Physical therapist (PT) indicated R44 would have had an assessment for ROM; the person who did the assessment no longer worked for the company. PT indicated he had not met R44 and does not have orders to see R44. PT reviewed R44s chart and indicated R44 was a resident at the facility and left, and when R44 was readmitted in January 2026. R44 requested ROM as there were no orders for physical therapy. PT indicated recommendations for restorative program were in the restorative book in the therapy cupboard. PT indicated the therapy department does not oversee the restorative nursing program. PT indicated no measurements were done on extremities and would be unable to indicate if there was a decline in ROM. PT was not notified of a decline in strength or ROM for R44. PT would expect if the RNA saw a decline, the restorative aid to notify nursing, and nursing would notify therapy. Therapy would request an order from the physician for treatment. PT was unaware who oversees the RNA and if ROM was being completed as ordered. During an interview on 7/15/26 at 10:32 a.m., director of nursing (DON) indicated the process for physical therapy to evaluate a resident, put together a program, and give the program to the nurses. The programs are looked at routinely to ensure the program is still appropriate. The NAs are trained on how to perform ROM, and there were sheets in residents rooms on the programs. When RNA was not working, the programs were triggered on the Kardex for the NAs to complete. If there is a task that is blank, it cannot be assumed it was refused or completed. DON expectation would be for RNA to inform the care coordinator if a program was not completed. All NA's could document in the task section when the program was completed, refused, or NA if a resident is out for an appointment. DON indicated it was not brought to her attention that some of the restorative programs were not being completed as ordered. DON reviewed the documentation and confirmed that restorative programs were not being done as ordered for R44. DON indicated ROM is important for mobility and quality of life, pain reeducation, and prevention of contractors. A policy titled Nursing Rehab Services dated 4/26 identified residents will receive nursing			F0825			08/07/2026

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F0825 SS = D	Continued from page 12 rehab services as needed to help promote optional safety and independence. Rehab nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative service. Residents maybe started on a nursing rehab program upon admission, during the course of stay or when discharged from rehabilitation care. Rehab goals and objectives are individualized and resident-centered and are outlined in the residents plan of care. Rehab goals may include but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities, developing, maintaining, or strengthening his/her physiological and psychological resources; maintain his/her dignity, independence, and self-esteem. And participating in their development and implementation of his/ her plan of care. Resident participation and effectiveness will be periodically reviewed for the continued appropriateness and/or need for further rehabilitation services.			F0825			08/07/2026
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: (i) A system of surveillance designed to identify possible communicable diseases or			F0880	Date of Completion: 8/07/2026 Date of Survey: 7/13/2026-7/15/2026 Tag Number / Description: F0880- Infection Prevention & Control Regulatory requirements: The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: The hand hygiene procedures to be followed by staff involved in direct resident contact. Description of how the requirement was not met: Requirement not met as evidence by: Failed to ensure infection prevention practices including hand hygiene were followed during wound cares for 1 of 1 residents (R29) observed for wound cares. Drafted plan of correction: The facility will complete appropriate hand hygiene infection prevention practices during wound care for all residents including R29. Re-education will be completed with nursing staff		08/07/2026

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F0880 SS = D	Continued from page 13 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 ensure infection prevention practices including hand hygiene were followed during wound cares for 1 of 1 residents (R29) observed for wound cares. Findings Include: R29's quarterly Minimum Data Set			F0880	Continued from page 13 regarding the facility policy on “Handwashing/Hand Hygiene” and “Wound Care”. The Director of Nursing and/or designee will completed observational audits to assure that appropriate hand hygiene infection prevention practices during wound care is followed. Audits will be performed three times a week for two weeks, then two times a week for two weeks, then once a week until the next Quality Assurance Committee meeting at which time audit results will be reported to and reviewed to ensure sustained compliance.		08/07/2026

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F0880 SS = D	Continued from page 14 (MDS) dated 6/16/26, identified R29 was cognitively intact and had diagnosis which included; diabetes mellitus, coranary artery disease, and hypertension. R29's MDS identified R29 was dependent for dressing lower half, transfer, toileting and required substantial/maximal assistance with rolling in bed side to side. R29 had one stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or with directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). R29's Care Area Assessment (CAAS) dated 12/19/25, identified R29 had alteration in skin integrity due to being admitted with chronic pressure ulcers and diabetic foot ulcers. R29's CAAS identified R29 was often noncompliant with repositioning and often refused to get out of bed. R29's Wound Observation Tool dated 7/15/26, identified R29 had a stage 4 pressure ulcer on his coccyx, 2 centimeters (cm) lenght, 1 cm width and 3 cm depth. Summary identified wound stable, no change. No signs or symptoms of infection, with a small amount of serosanguineous drainage. Surrounding (peri) wound skin intact and within normal limits. R29's care plan revised 6/11/26, identified R29 had alteration in skin integrity related to chronic pressure ulcer and diabetic foot ulcer. Interventions included air pressure mattress, nutritional supplements, and turn and repostion per tissue tolerance. During observation on 7/15/26 at 9:54 a.m., clincial manager registered nurse (RN)-A applied gown and gloves and was joined by assistant director of nursing (ADON) who also applied gown and gloves. RN-A and ADON entered R29's room and RN-A asked R29 if they could check his skin, and he agreed. ADON stood on R29's right side of bed, and RN-A was on R29's left side. R29's bed was raised up, and they removed R29's sheet and pillows under R29's sides and legs. They removed the tabs on R29's brief, and completed perineal cares to R29's front using wipes. They then assisted R29 to his right side. R29 had a large amount of soft grey stool on buttocks, whick RN-A began to cleanse off with wipes. RN-A removed gloves, and applied new gloves. RN-A placed R29's brief in garbage, rolled the soiled disposable chux up and placed a new chux on R29's left side. RN-A removed gloves, then placed new gloves on. RN-A removed R29's dressing over coccyx pressure ulcer, then noted more stool on R29's buttocks and upper thigh, so began again to cleanse area with wipes. RN-A removed gloves, then applied new gloves. RN-A did not once sanitize her hands after removing soiled gloves. RN-A then gathered wound care supplies and placed on new chux near R29's buttocks. RN-A removed wound packing from R29's wound, then began to measure the wound. RN-A then removed new packing from			F0880			08/07/2026

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F0880 SS = D	Continued from page 15 the small brown glass bottle and began to pack R29's pressure wound. RN-A used a scissors to cut of the strip, then applied a bandage over the coccyx pressure ulcer, using tape on the top edge of dressing. RN-A did not sanitize hands or change gloves prior to beginning packing wound and applying new dressing. RN-A then removed the soiled strip from the chux, placed in can and placed other supplies and scissors on the bedside table. RN-A and ADON then assisted R29 with new brief, checked skin on heels and abdomen then positioned R29 with pillows. RN-A removed gown and gloves and sanitized hands. During interview on 7/15/26 at 10:50 a.m., RN-A indicated was new to position and still learning. RN-A indicated her usual practice did not include R29's wound cares. RN-A confirmed she had not sanitized her hands after each time her gloves were changed. RN-A also confirmed she had not sanitized her hands or changed gloves after removing R29's soiled packing, before applying R29's new wound packing and dressing. RN-A indicated sanitizing hands when changing gloves was important. RN-A also indicated removing gloves and sanitizing hands was important between removing soiled dressings and applying new dressings for infection control. During interview on 7/15/26 at 11:06 a.m., director of nursing (DON) indicated her expectation was that every time gloves were removed staff should sanitize their hands. DON also stated after a wound was cleansed, staff should remove gloves, wash hands and apply new gloves prior to applying new dressings. DON stated it was important to prevent infection. DON indicated the facility planned to have a skills fair the next day, and they would be reviewing hand hygiene and glove use. The facility policy titled Handwashing/Hand Hygiene dated 9/25, identified all staff would be trained on the importance of hand hygien in preventing the transmission of healthcare-associated infections. All staff would the procedures to help the spread of infections ot other personnel, residents and visitors. The policy interpretation and implementation identified an alcohol-based hand rub should be used for the following situations:-handling clean or soiled dressings-before moving from a contaminated body site to a clean body site during resident care-after removing gloves-after handling clean or soiled dressings -after contact with a resident's intact skin-after handling used dressings, contaminated equipmentThe use of gloves does not repale hand washing/hand hygiene. The facility policy titled Wound Care dated 1/25, included the following instructions. Prepare a clean field on the resident's overbed table or another appropriate surface in resident's room. Place all items to be used during			F0880			08/07/2026

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F0880 SS = D	Continued from page 16 procedure on the clean field. Peform hand hygiene, don gloves. Cleanse the wound, discard disposable items and remove and discard soiled gloves. Perform hand hygiene. Don gloves, proceed with dressing the wound as ordered. Remove and discard gloves, perform hand hygiene.			F0880			08/07/2026
F0585 SS = C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and			F0585	Date of Completion: 8/07/2026 Date of Survey: 7/13/2026-7/15/2026 Tag Number / Description: F0585- Grievances Regulatory requirements: Grievances. The facility must make information on how to file a grievance or complaint available to the resident. Description of how the requirement was not met: Requirements not met as evidence by: Failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 3 of 3 (R10, R28, R42) resident council members interviewed. This had the potential to affect all 52 residents who resided in the facility. Drafted plan of correction: Grievance forms were placed in all households for ease of access for all residents and resident representatives (including R10, R28, R42) on 7/14/26 upon being informed by surveyor that they were not in place. Facility staff will receive re-education on grievances process. Additionally the facility grievance process will be reviewed with residents at the next resident council and residents will be provided a tool educating them on the facility grievance process. The administrator and/or designee will complete an audit to assure that the facility grievance procedure and forms are posted and available. Audits will be performed once a week for two weeks then monthly until the next Quality Assurance Committee meeting at which time audit results will be reported to and reviewed to ensure sustained compliance.		08/07/2026

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F0585 SS = C	Continued from page 17 State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations			F0585			08/07/2026

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F0585 SS = C	Continued from page 18 throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 3 of 3 (R10, R28, R42) resident council members interviewed. This had the potential to affect all 52 residents who resided in the facility. Findings include:On 7/14/26 at 11:00 a.m., a resident council meeting was held with three residents which included R10, R28 and R42. During the resident council meeting, all three residents indicated they were not aware how to file a grievance. During an observation on 7/14/26 at 11:40 a.m., a walk through was conducted on each unit of the facility which reveale no grievance forms or procedures were posted for residents or resident repretativies to refer to. During an interview on 7/14/26 at 11:50 a.m., acitivity director (AD)-A indicated during resident council meetings she had informed residents they could have social services fill out a grievance form with them. AD-A indicated the grievance officer was social services and the administrator. AD-A confirmed was not aware of last time spoke to residents about filing grievances. AD-A indicated she did not have a copy of the grievance form and was not aware of which form to use since they had new owners. During interview on 7/14/26 at 12:16 p.m., licensed social worker (LSW)-A stated her usual process was to address the concern right away and document the results in the resident's progress notes. LSW-A indicated a resident could file a grievance with her, or complete one with the ombudsman. LSW-A stated residents could obtain a form from her if wanted to keep it annonyomous, and she would keep it confidential. LSW-A confirmed she was the grievance office, and no grievance forms had been completed for months, but could not remember when. Review of grievance log identified last grievance form was completed December of 2025. During interview on 7/14/26 at 12:21 p.m. administrator confirmed the grievance policy and grievance forms were not located in prominant locations through out the facility for residents or resident representatives to complete. Administrator indicated residents could ask social services for forms and assistance to complete them. Administrator stated all staff had access to the grievance forms. Administrator confirmed residents were not able to file a grievance anonymously. The facility policy titled Grievance Policy dated 4/26, identified the purpose was the resident had the right to vice grievances to any staff member or anonymouslyto the facility, or other agency or entity that heard grievances without discrimination or reprisal and with fear of discrimination or reprisal. Grievance information would be posted in the facility and would include, the right to file grievances, the			F0585			08/07/2026

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F0585 SS = C	Continued from page 19 right to file anonymously, and the contact information of the grievance official.			F0585			08/07/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/14/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cura of Willmar was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			07/31/2026

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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K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cura of Willmar is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both inspected as buildings under Existing Healthcare requirements. The first addition was built in 2011 and is a 1-story addition without a basement that is located on the south side and was determined to be of Type V(111) construction. The second addition was built in 2012 and is a 1-story addition without a basement that is located on the south side of the northeast wing of and was determined to be of Type V(111) construction. The third addition was built in 2013 and is a 1-story addition without a basement that is located on the south side of the northwest wing and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two buildings that were both built in 2014, both additions are 1-story additions without basements that are located on the west side of the 2011 addition. It was determined that the 2014 additions are of Type V(111) construction. Surveyed as one building. The building is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a			K0000			07/31/2026

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K0000 Bldg. 01	Continued from page 2 census of 53 at the time of the survey.			K0000			07/31/2026
K0914 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/14/2026 at 12:57 PM, it was revealed by review of available documentation that the facility had not tested electrical receptacles since 04/09/2025. Testing intervals shall not exceed 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0914	The Maintenance Director or qualified electrical contractor will be testing all required hospital-grade and non-hospital-grade electrical receptacles in accordance with NFPA 99 requirements, and documentation of the testing will be completed and maintained. Any receptacles identified as needing repair or replacement will be corrected. The Maintenance Director was re-educated on the facility's existing preventive maintenance program and NFPA 99 requirements regarding required testing intervals, documentation, and timely completion of electrical receptacle inspections to ensure ongoing compliance. The Maintenance Director or designee will complete audits of 5 electrical receptacles by visually inspecting each receptacle and cover to ensure they are intact and in good condition, using a receptacle tester to verify continuity of the ground and proper polarity, and using a ground blade tension tester to verify the tension is greater than 4 ounces. Audits will be conducted three days per week for two weeks, two days per week for four weeks, and then weekly until the results are reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified deficiencies will be corrected immediately, and additional education provided as needed.		08/28/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure			K0321	The Storage Room door next to Room 329 and the Soiled Utility Room 313 door were repaired to ensure both doors fully closed and positively latched when released from the self-closing device. A video demonstrating that both doors were functioning properly was provided to the State Fire Marshal on		07/15/2026

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K0321 SS = E Bldg. 01	Continued from page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. These deficient findings could have a patterned impact on residents within the facility. Findings include: On 07/14/2026 at 1:48 PM, it was revealed by observation that the Storage Room door next to room 329 did not latch when closed using the self-closing device.			K0321	Continued from page 3 July 15, 2026. The Maintenance Director was re-educated on the facility's existing preventive maintenance program and NFPA Life Safety Code requirements regarding routine inspection of hazardous area doors to ensure self-closing devices function properly and doors fully latch when closed. Any deficiencies identified will be repaired promptly to maintain the integrity of hazardous area enclosures. The Maintenance Director or designee will audit 3 of the facility's doors by verifying that each door closes completely using the self-closing device, positively latches, and is free from visible damage or obstruction. Audits will be conducted three days per week for two weeks, two days per week for four weeks, and then weekly until the results are reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified deficiencies will be corrected immediately, and additional education will be provided as needed.		07/15/2026

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K0321 SS = E Bldg. 01	Continued from page 4 On 07/14/2026 at 1:51 PM, it was revealed by observation that the door for Soiled Utility Room 313 did not latch when closed using the self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0321			07/15/2026
K0351 SS = D Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 6.2.7.1, and 8.3.1.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 07/14/2026 at 1:41 PM, it was revealed by observation that the escutcheon plate was missing from the fire sprinkler head located by the door between the main kitchen and the gathering place. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0351	The missing escutcheon plate on the fire sprinkler head located by the door between the main kitchen and the Gathering Place will be replaced, restoring the sprinkler assembly to compliance with NFPA 13 requirements. The Maintenance Director was re-educated on the facility's existing preventive maintenance program and NFPA requirements regarding routine inspection of the fire sprinkler system, including verifying that sprinkler heads and escutcheon plates remain intact and unobstructed and that any deficiencies are corrected promptly. The Maintenance Director or designee will audit 5 of the facility's sprinkler heads by visually verifying that each sprinkler head has an intact escutcheon plate, is free from damage, and is not obstructed. Audits will be completed three days per week for two weeks, two days per week for four weeks, and then weekly until the results are reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified deficiencies will be corrected immediately, and additional education will be provided as needed.		08/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245410		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/14/2026	
NAME OF PROVIDER OR SUPPLIER CURA OF WILLMAR				STREET ADDRESS, CITY, STATE, ZIP CODE 1801 WILLMAR AVENUE SOUTHWEST , WILLMAR, Minnesota, 56201			
(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
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire and smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.1.3.1, and 5.1.5.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 07/14/2026 at 1:23 PM, it was revealed by observation that the latching mechanism at the top of fire and smoke barrier doors by rooms 201 and 203 did not close completely and latch when using the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	The fire and smoke barrier doors located by Rooms 201 and 203 were repaired to ensure the self-closing devices fully closed and positively latched. A video demonstrating the corrected operation of the doors was provided to the State Fire Marshal on July 15, 2026. The Maintenance Director was re-educated on the facility's existing fire door inspection and preventive maintenance program, including the requirement to routinely inspect fire and smoke barrier doors to ensure they close and latch properly and to promptly address any deficiencies identified. The Maintenance Director or designee will audit 3 of the facility's fire and smoke barrier doors by verifying that each door self-closes completely, positively latches, and is free from visible damage or obstruction. Audits will be completed three days per week for two weeks, two days per week for four weeks, and then weekly until the results are reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified deficiencies will be corrected immediately, and additional education will be provided as needed.		07/15/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2026

Administrator
CURA OF WILLMAR
1801 WILLMAR AVENUE SOUTHWEST
WILLMAR, MN 56201

RE: CCN: 245410
Cycle Start Date: July 15, 2026

Dear Administrator:

On August 31, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us