Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 18, 2024

Administrator
Cura of Melrose
525 West Main Street
Melrose, MN 56352

RE: CCN: 245396
Cycle Start Date: August 29, 2024

Dear Administrator:

On October 1, 2024, the Minnesota Departments 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2024

Administrator
Cura of Melrose
525 West Main Street
Melrose, MN 56352

Re: Reinspection Results
Event ID: GS5S12

Dear Administrator:

On October 1, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 9, 2024

Administrator
Cura Of Melrose
525 West Main Street
Melrose, MN 56352

RE: CCN: 245396
Cycle Start Date: August 29, 2024

Dear Administrator:

On August 29, 2024, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 November 29, 2024 (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 March 1, 2025 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	525 WEST MAIN STREET MELROSE, MN 56352

(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
E 000	Initial Comments On 8/26/24 through 8/29/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 08/26/24 throught 8/29/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: MN00104750-H53967289C with a deficiency cited at F550. AND MN00097987-H53967290C MN00102051-H53967288C with no deficiencies cited. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/19/2024

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.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		9/24/24

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide a reasonable call light response time for 4 of 4 (R27, R13, R36, R10) residents reviewed for dignity. Findings include: R27's quarterly MDS dated 6/28/24, indicated R27 was cognitively intact, and had the following diagnoses: anemia, HLD, depression, and post traumatic stress disorder (PTSD). R13's significant change MDS dated 7/11/24, indicated R13 was cognitively intact and had the following diagnoses: anemia (low blood count), atrial fibrillation (AFIB) (top two chambers of the heart beat irregularly), HTN, congestive heart failure (CHF) (heart does not pump blood efficiently), renal insufficiency (kidneys filter the blood ineffectively), HLD, and hyponatremia (low sodium levels in the body), and arthritis. R36's annual MDS dated 5/10/24, indicated R36 was cognitively intact and had the following diagnoses: cerebral vascular accident (CVA) (stroke), anemia, coronary artery disease (CAD) (hardening of the cardiac arteries), benign prostatic hyperplasia (BPH) (enlarged prostate), renal insufficiency, HLD, dementia, and depression.	F 550	/The facility will take the following measures to ensure that the same practice will not recur; The call light system display board has been updated to improve response times and responding in order. Additionally, the call light system vendor has been contacted to implement an ability for call light indicators to be made available on portable devices. The server was upgraded on 9/16/24 and the facility is actively communicating with the vendor to install the appropriate software to finalize the communication of the server with the portable devices. Facility staff will be re-educated on the importance of responding to call lights timely and the appropriate order for responding to call lights to assure residents needs are being met timely. The facility will take the following corrective action for the affected and other resident that have the potential to be affected by: The social services representative or designee will conduct weekly interviews with R27, R13, R36 and R10 as well as sampling of other residents to assure they feel their needs are being met in a timely and dignified manner. These interviews will be	

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F 550	Continued From page 3 R10's quarterly Minimum Data Set (MDS) dated 6/26/24, indicated R10 was cognitively intact, and had the following diagnoses: hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (elevated levels of fat in the blood), anxiety and depression. The Device activity report dated 6/29/24, listed call light times for a 24-hour period and had 36 response times greater than 30 minutes, 7 greater than 60 minutes, and the longest response time was 2 hours and 21 minutes. The Device activity report dated 8/21/24, listed call light times for a 10-hour period and had 14 response times greater than 30 minutes, 3 greater than 60 minutes, and the longest response time was 1 hour and 27 minutes. The Device activity reported dated 8/23/24 through 8/24/24, listed call light times for a 14-hour period and had 23 response times greater than 30 minutes, 8 greater than 60 minutes, and the longest response time was 1 hour 45 minutes. On 8/29/24 at 10:31 a.m., nursing assistant (NA)-E stated they felt that cares were not getting done, they felt rushed and unable to spend time with the residents they would like to. NA-E stated the call lights will be relayed by nursing staff or whoever was near the monitors which list out who called first. NA-E stated 5-6 minutes was an acceptable response time for call lights. The Device activity report dated 8/23/24 through 8/24/24, listed a call light time of 60 minutes for R27. On 8/29/24 at 11:06 a.m., R27 confirmed	F 550	conducted weekly x 4 weeks, then once a month until the next QAA committee meeting. Interview results will be reviewed at the monthly safety committee meeting and reported to QAA committee ensuring continued compliance. Facility monitoring of performance to ensure that solutions are maintained: The Director of Nursing and/or designee will complete weekly audits of device activity reports weekly x4 weeks and then as needed. Audit results and interview results will be reviewed at the monthly safety committee meeting and reported to QAA committee for review and determination of appropriate frequency for ongoing audits.	

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F 550	Continued From page 4	F 550		

they had experienced long call light response times. R27 stated they were unable to make it to the restroom because of the long response time and urinated in their chair while waiting for help to come. R27 stated they felt "angry" when it took so long to get help.

The Device activity reported dated 8/23/24 through 8/24/24, listed a call light time of 1 hour and 16 minutes for R13. On 8/29/24 at 11:16 a.m., R13 confirmed they had experienced long call light response times. R13 stated they are very independent and only need help with a few things from staff, so when they must wait so long it made them feel "upset and angry" when they, "only put on the light a few times and still no one comes".

The Device activity report dated 6/29/24, listed a call light time of 1 hour 57 minutes for R36. On 8/29/24 at 11:24 a.m., R36 confirmed they had experienced long call light response times. R36 stated they had been unable to get to the rest room in time and had soiled their bed. R36 stated they were "frustrated and mad" when they had to wait so long and were unable to make it to the bathroom.

The Device activity report dated 6/29/24, listed a call light time of 1 hour and 10 minutes for R10. On 8/29/24 at 11:30 a.m., R10 confirmed they had experienced long call light response times. R10 stated they were unable to make it to the rest room while waiting for assistance and R10 was very "upset" and it made them "feel bad" to have to wait so long for help.

On 8/29/24 at 10:50 a.m., licensed practical nurse (LPN)-A stated they feel rushed and were not

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F 550	Continued From page 5 able to spend as much time as they would like with the residents to complete their workload. LPN-A stated lights were called out over the walkie talkies, informing staff which lights were on and which had been on the longest. LPN-A stated residents had reported to them in the past they had been waiting a long time and were frustrated. LPN-A stated 15 minutes was an acceptable response time. On 8/29/24 at 11:36 a.m., the director of nursing (DON) (O)-B confirmed the facility's call light logs had reflected excessively long wait times and they were aware of the problem. The DON expected call lights to be responded to within 15 minutes. DON stated they were currently working to implement a new call light program which would be linked to the staff's Ipads and allow them to see which lights had been on the longest and assist them in expediting call light response times. DON stated they were working to improve communication with staff, residents and the overall culture of the facility in order to help prevent falls, meet resident needs and ensure a home-like environment for the residents.	F 550		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		9/24/24

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F 688	Continued From page 6 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent further development of decreased range of motion and ability for 2 of 2 residents (R29, R53) reviewed for positioning and mobility. Findings include: R29's annual Minimum Data Set (MDS) dated 7/5/24, included diagnosis of stroke, arthritis, and hemiplegia or hemiparesis (weakness or inability to move one side of your body). R29's annual MDS included he had limited range of motion on one side of his upper body. On 8/27/24 at 11:39 a.m., R29 was positioned by staff at a table in the dining room. Right arm was noted to be on his lap with right hand curled inward. R29's care plan dated 8/2/24, included a restorative nursing intervention of passive range of motion for right upper and lower extremities which included passive stretching and extensions of the right fingers and thumb. R29's occupational therapy discharge summary dated 7/14/24, included discharge	F 688	Corrective action for the affected resident(s): R29 care plan and interventions were reviewed. R53 care plan and interventions were reviewed. The facility will take the following measures to ensure that the same practice will not recur: All direct care staff were provided education on the expectation for appropriate implementation of range of motion programs as care planned and documenting appropriately. Facility RN leadership were re-educated on overseeing and reviewing range of motion programs for effectiveness. The facility will identify other residents that have the potential to be affected in the same manner by: an audit was conducted on all the facilities residents and identified residents that have range of motion/restorative programs to assure those residents have appropriate care plans and interventions. Facility monitoring of performance to ensure that solutions are maintained: The Director of Nursing and/or designee will	

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F 688	Continued From page 7 recommendations for passive range of motion to R29's right upper extremity. R29's Follow Up Question report for 7/1/24 to 7/31/24, included a task for passive range of motion to fingers and wrist. Responses were as follows: "Resident refused" was documented 6 times "Resident not available" was documented 1 time "Not applicable" was documented 6 times Missing documentation or zero minutes was documented 11 times Task was documented as complete 10 times R29's Follow Up Question report for 8/1/24 to 8/29/24, included a task for passive range of motion to fingers and wrist. Responses were as follows: "Resident not available" was documented 2 time "Not applicable" was documented 13 times Missing documentation or zero minutes was documented 12 times Task was documented as complete 1 time During interview on 8/28/24 at 7:26 a.m., nursing assistant (NA)-A stated she did not have time to do range of motion. NA-A stated "not applicable" would be documented under the range of motion task if it was not offered and not completed. During interview on 8/29/24 at 8:27 a.m., director of therapy (DOT) stated it was very important for R29 to have his range of motion completed to prevent development of contractures and loss of range of motion in his joints. R53's quarterly Minimum Data Set (MDS) dated 5/31/24, indicated R53 was severely cognitively impaired, and had the following diagnoses:	F 688	conduct random chart audits for residents that have designated range of motion programs to assure care plans and interventions are completed and documented appropriately. Audits will be completed three times a week for a week, two times a week for two weeks, then weekly until the next Quality Assurance Committee. Results of the audits will be reviewed with members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	

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F 688	Continued From page 8 anemia (low iron in the blood), hypertension (HTN) (high blood pressure), renal insufficiency (kidneys not working properly/failing), dementia, malnutrition, anxiety and depression. R53's medical record indicated a restorative nursing program for passive range of motion (ROM) for bilateral (both sides) lower extremities daily and as needed on nights and evenings. The follow up question report dated 6/1/24 through 6/30/24, indicated the number of minutes spent completing the program, refusals and not applicable documentation of the ROM program. "Resident refused" was documented 2 times "Not applicable" was documented 9 times Task was documented as complete 9 times From 7/1/24 through 7/28/24: "Resident refused" was documented 1 times "Not applicable" was documented 19 times Task was documented as complete 6 times The undated Follow up Question: Question 1, indicated the number of minutes spent completing the ROM program, refusals and not applicable. From 8/1/24 through 8/27/24: 1 out of 21 days the program was completed. 1 out of 21 days showed zero minutes completed. 19 out of 21 days not applicable. R53's medical record lacked any rational or reasoning why the ROM program would not have been completed on the above listed days. On 8/26/24 at 2:27 p.m., R53's family member (O)-C stated R53 had a ROM program for their legs but it was only done when the staff had time.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	C 08/29/2024

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F 688	Continued From page 9	F 688		

O-C felt R53 could have benefited from the ROM program.

On 8/29/24 at 10:31 a.m., the nursing assistant (NA)-E stated they would complete the ROM program sometimes, but only if they had time. NA-E stated they normally documented if the ROM was completed in the task tabs in point click care (PCC) and put how long they preformed the ROM program and would leave it blank if they did not have time to do it.

On 8/29/24 at 10:50 a.m., the licensed practical nurse (LPN)-A stated R53 had a ROM program which began in January of this year. LPN-A stated the facility used to have a restorative aide, but not anymore, and they rarely had the time to complete the program. LPN-A stated the NA's and nurses can complete the program and it was documented in the task tab of PCC and they would put "not applicable" when it was not completed. LPN-A stated when ROM was not completed it should have been reported to the nurse on duty but they very rarely had time to check and see it was completed or document why not.

During interview on 8/29/24 at 9:53 a.m., director of nursing (DON) stated a task should have been documented in the resident's chart if it was completed. The floor nurse should have been updated if a resident was refusing. The DON confirmed R29 had a task for passive ROM and the task was often documented as "not applicable." The DON stated completing passive ROM was important to keep residents at their current health status.

Facility policy Restorative Nursing Services dated

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F 688	Continued From page 10 January 2024, included resident would receive restorative nursing care as needed to help promote safety and independence.	F 688		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 9, 2024

Administrator
Cura Of Melrose
525 West Main Street
Melrose, MN 56352

Re: State Nursing Home Licensing Orders
Event ID: GS5S11

Dear Administrator:

The above facility was surveyed on August 26, 2024 through August 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/26/24 through 8/29/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent further development of decreased range of motion and ability for 2 of 2 residents (R29, R53) reviewed for positioning and mobility. Findings include: R29's annual Minimum Data Set (MDS) dated 7/5/24, included diagnosis of stroke, arthritis, and hemiplegia or hemiparesis (weakness or inability to move one side of your body). R29's annual MDS included he had limited range of motion on one side of his upper body.	2 895	Corrected 9/24/2024	9/24/24

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2 895	Continued From page 3 On 8/27/24 at 11:39 a.m., R29 was positioned by staff at a table in the dining room. Right arm was noted to be on his lap with right hand curled inward. R29's care plan dated 8/2/24, included a restorative nursing intervention of passive range of motion for right upper and lower extremities which included passive stretching and extensions of the right fingers and thumb. R29's occupational therapy discharge summary dated 7/14/24, included discharge recommendations for passive range of motion to R29's right upper extremity. R29's Follow Up Question report for 7/1/24 to 7/31/24, included a task for passive range of motion to fingers and wrist. Responses were as follows: "Resident refused" was documented 6 times "Resident not available" was documented 1 time "Not applicable" was documented 6 times Missing documentation or zero minutes was documented 11 times Task was documented as complete 10 times R29's Follow Up Question report for 8/1/24 to 8/29/24, included a task for passive range of motion to fingers and wrist. Responses were as follows: "Resident not available" was documented 2 time "Not applicable" was documented 13 times Missing documentation or zero minutes was documented 12 times Task was documented as complete 1 time During interview on 8/28/24 at 7:26 a.m., nursing assistant (NA)-A stated she did not have time to	2 895		

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2 895	Continued From page 4 do range of motion. NA-A stated "not applicable" would be documented under the range of motion task if it was not offered and not completed. During interview on 8/29/24 at 8:27 a.m., director of therapy (DOT) stated it was very important for R29 to have his range of motion completed to prevent development of contractures and loss of range of motion in his joints. R53's quarterly Minimum Data Set (MDS) dated 5/31/24, indicated R53 was severely cognitively impaired, and had the following diagnoses: anemia (low iron in the blood), hypertension (HTN) (high blood pressure), renal insufficiency (kidneys not working properly/failing), dementia, malnutrition, anxiety and depression. R53's medical record indicated a restorative nursing program for passive range of motion (ROM) for bilateral (both sides) lower extremities daily and as needed on nights and evenings. The follow up question report dated 6/1/24 through 6/30/24, indicated the number of minutes spent completing the program, refusals and not applicable documentation of the ROM program. "Resident refused" was documented 2 times "Not applicable" was documented 9 times Task was documented as complete 9 times From 7/1/24 through 7/28/24: "Resident refused" was documented 1 times "Not applicable" was documented 19 times Task was documented as complete 6 times The undated Follow up Question: Question 1, indicated the number of minutes spent completing the ROM program, refusals and not applicable.	2 895		

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2 895	Continued From page 5 From 8/1/24 through 8/27/24: 1 out of 21 days the program was completed. 1 out of 21 days showed zero minutes completed. 19 out of 21 days not applicable. R53's medical record lacked any rational or reasoning why the ROM program would not have been completed on the above listed days. On 8/26/24 at 2:27 p.m., R53's family member (O)-C stated R53 had a ROM program for their legs but it was only done when the staff had time. O-C felt R53 could have benefited from the ROM program. On 8/29/24 at 10:31 a.m., the nursing assistant (NA)-E stated they would complete the ROM program sometimes, but only if they had time. NA-E stated they normally documented if the ROM was completed in the task tabs in point click care (PCC) and put how long they preformed the ROM program and would leave it blank if they did not have time to do it. On 8/29/24 at 10:50 a.m., the licensed practical nurse (LPN)-A stated R53 had a ROM program which began in January of this year. LPN-A stated the facility used to have a restorative aide, but not anymore, and they rarely had the time to complete the program. LPN-A stated the NA's and nurses can complete the program and it was documented in the task tab of PCC and they would put "not applicable" when it was not completed. LPN-A stated when ROM was not completed it should have been reported to the nurse on duty but they very rarely had time to check and see it was completed or document why not. During interview on 8/29/24 at 9:53 a.m., director	2 895		

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2 895	Continued From page 6 of nursing (DON) stated a task should have been documented in the resident's chart if it was completed. The floor nurse should have been updated if a resident was refusing. The DON confirmed R29 had a task for passive ROM and the task was often documented as "not applicable." The DON stated completing passive ROM was important to keep residents at their current health status. Facility policy Restorative Nursing Services dated January 2024, included resident would receive restorative nursing care as needed to help promote safety and independence. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		9/24/24

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21426	Continued From page 7 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing was completed for 1 of 5 staff {nursing assistant (NA)-D} reviewed for TB testing. Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. The unlabeled facility staff listing (undated) included a start date for NA-D of 2/21/24.	21426	Corrected 9/24/24	

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21426	Continued From page 8 During interview on 8/29/24 at 11:03 a.m., director of nursing (DON) stated she was unable to find documentation showing NA-D completed a screening or TB testing. DON confirmed NA-D should have completed the screening and started the testing upon employment. DON stated NA-D was removed from the schedule until these were completed. Facility policy titled Tuberculosis Infection Control Program dated April 2024, included screening and surveillance of residents and employees for TB would be completed by the infection preventionist. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		

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	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2024**

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CURA OF MELROSE	**525 WEST MAIN STREET** **MELROSE, MN 56352**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 29, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cura of Melrose, 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	**525 WEST MAIN STREET** **MELROSE, MN 56352**

(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
K 000	Continued From page 1 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 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. The original building was constructed in 1961, is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(000) construction; The 1969 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type V(111) construction;	K 000		

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K 000	Continued From page 2 The 1994 addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction. The 2007 resident wing addition is one-story in height, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction. Both building are surveyed as one. The facility has a capacity of 75 beds and had a census of 63 at the time of the survey.	K 000		
K 362 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.	K 362		10/7/24

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K 362	Continued From page 3 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/29/2024 between 12:00 PM and 2:00 PM, it was revealed by observation that there was a penetration in the firewall that leads to the corridor in the electrical room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 362	Corrective action for the affected resident(s): Fire caulk was utilized to fill the firewall penetration on 9/12/2024. The facility will take the following measures to ensure that the same practice will not recur: The Maintenance director will complete a visual inspection of areas to assure any firewall penetrations are appropriately sealed after any work is completed in that area. The facility will identify other residents that have the potential to be affected in the same manner by: Standard observations for firewall penetrations to be completed during routine maintenance. Facility monitoring of performance to ensure that solutions are maintained: Standard observations for firewall penetrations to be completed during routine maintenance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates	K 923		10/7/24

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K 923	Continued From page 4 outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2. This deficient finding could have a widespread impact on residents within the facliity. Findings include:	K 923	Corrective action for the affected resident(s): Oxygen rooms 17 and 14 had excessive oxygen cylinders removed to assure the maximum amount of oxygen does not exceed compartment maximum. Excessive oxygen cylinders moved to alternate locations to remain in compliance.	

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K 923	Continued From page 5 On 08/29/2024 between 12:00 PM and 2:00 PM, it was revealed by observation that in oxygen storage room 17 and 14, the quantities of E size cylinders exceeded that allowable 300 ft3 per compartment. Neither room was properly rated for quantities greater than 300ft3. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	The facility will take the following measures to ensure that the same practice will not recur; Education was provided to Eric Gill, maintenance director on 9/19/2024. The facility took the following action to confirm compliance in other areas throughout the facility that had the potential to be affected in the same manner: A full facility walk through was completed by Eric Gill on 9/19/2024 to assure all areas mets compliance. Facility moniotring of performance to ensure that solutions are maintained: The maintenance director or designee will audit the number of oxygen cylinders per oxygen storage room weekly x4 weekx and then monthly until the next QAPI committee meeting.	