Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2026

Administrator
CURA OF MELROSE
101 5TH AVENUE NW
MELROSE, MN 56352

RE: CCN: 245396
Cycle Start Date: July 8, 2026

Dear Administrator:

On July 8, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 29, 2026, the situation of immediate jeopardy to potential health and safety cited at *F0689: Free of Accident Hazards/Supervision/Devices* was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money

penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 8, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, CURA OF MELROSE is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 8, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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July 23, 2026

Administrator
CURA OF MELROSE
101 5TH AVENUE NW
MELROSE, MN 56352

Re: Event ID: 25CFBA-H1

Dear Administrator:

The above facility survey was completed on July 8, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	**101 5TH AVENUE NW , MELROSE, Minnesota, 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
F0000	INITIAL COMMENTS On 7/7/26 to 7/8/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H13303125C (3063442) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = SQC-J	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 §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 interview and document review, the facility failed to provide adequate supervision to prevent the elopement for 1 of 1 residents (R1) reviewed who was identified as an elopement risk, required a WanderGuard (a wireless wander management system to prevent residents from wandering or eloping. It uses a wearable bracelet paired with door sensors to trigger instant alarms if a resident approaches an exit) device and had exit-seeking behaviors. This resulted in Immediate Jeopardy (IJ)	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = SQC-J	Continued from page 1 when R1's WanderGuard device alarmed as she exited the building and staff responded by turning off the alarm without investigating who exited the door, she left the facility and independently ambulated approximately four blocks from the facility before being found, which placed R1 at likelihood for serious harm or death. The IJ began on 6/28/26 when R1 exited the building without staff awareness through the main front unit doors while having a WanderGuard device on and in place. A facility staff member observed R1 walking down the sidewalk approximately four blocks from the facility and alerted the facility of the elopement. R1 was found on a city main street used to travel through parts of the city and neighborhoods. The administrator, and director of nursing, and regional nurse consultant were notified of the immediate jeopardy on 7/8/26 at 4:18 p.m. The immediate jeopardy was removed on 6/29/26, when the facility provided staff education for all employees regarding the WanderGuard device use and turning off alarms, and the deficient practice corrected on 6/29/26, prior to the start of the survey and was therefore Past Noncompliance. Findings include: Video review revealed on 6/28/26, at approximately 2:04 p.m. R1 was observed exiting the building unsupervised with another resident who was able to go outside independently. R1's WanderGuard alarm was activated when she exited and staff responded within approximately one minute. Two staff responded to the alarm, however neither staff member conducted further investigation into why the alarm was activated and the alarm was shut off. R1 was admitted 7/21/2025 with diagnoses which included dementia, and generalized anxiety disorder. R1's quarterly Minimum Data Set (MDS) dated 3/27/26 indicated R1 had severe cognitive impairment, independent with ambulation, and required placement of a wander/elopement alarm device to be on at all times. R1's elopement/wandering risk assessment dated 4/22/2026, indicated R1 had a history of ambulating all over the town she resided in prior to admission. R1 frequently ambulated throughout the day since	F0689		

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F0689 SS = SQC-J	Continued from page 2 admission to facility. Due to memory impairment and lack of safety awareness, a WanderGuard device was placed on their left wrist. R1's care plan dated 4/17/26, indicated R1 had a risk for elopement related to impaired cognition and safety awareness that placed R1 at risk for injury outside of facility. R1 had a WanderGuard in place (left wrist). R1 loved to walk. Frequently walked the town for miles daily prior to admission. R1 frequently walked in the facility and wanted to walk outside despite undesirable weather conditions. R1 was difficult to redirect into the building at times. R1 would not leave the facility unattended. Interventions included to implement the WanderGuard device at all times. Risks and consequences of R1 leaving the facility included but are not limited to injury from minor to major, falls, up to and including death, without staff knowledge and/or without staff. The care plan was discussed with the R1 and R1 guardian. On 7/8/26, at 9:11 a.m. during an interview nursing assistant (NA)-B stated she had been working the day R1 eloped. She heard the front main door alarm go off and walked over to the door, but NA-A had already turned off the alarm. There were people standing outside so she did not think to find out why the alarm went off. She learned later the next day that R1 was found walking down the street and staff were re-educated on the WanderGuard device and door alarms. NA-B stated we all need to make sure residents are safe and in the building. Multiple attempts were made to interview NA-A but were unsuccessful. On 7/8/26, at 11:05 a.m. during an interview registered nurse (RN)-A stated on 6/28/26, at approximately 2:12 p.m. she was in her car coming back to the facility from her break when she saw R1 walking down the main street of the town. When she saw R1 walking alone approximately four blocks from the facility. RN-A stopped her vehicle, approached R1 and proceeded to escort R1 back to the facility. RN-A immediately called the facility and informed RN-B that she had found R1 walking down the street. RN-B called the facility administrator and was instructed to have staff check all door alarms and wander guards. Education also went out to all staff immediately related to wander guards and door alarms. R1's medical provider and guardian were	F0689		

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F0689 SS = SQC-J	Continued from page 3 also updated. All staff had training related to WanderGuards and making sure they respond to the alarm and further investigate. During interview on 7/8/26 at 1:01 p.m., administrator and director of nursing verified due to R1's cognitive impairment she was at risk of harm when she eloped on 6/28/26, due to lack of insight and judgement. Staff should not have turned off the alarm without first doing an investigation as to why the alarm was triggered. The staff that responded to the alarm did not do any type of investigation to find out why the alarm sounded, staff just turned off the alarm and walked away. Staff did not follow the facility policy, placing R1 at risk of injury. R1 could have sustained injury while crossing roads and lacked the ability to know how to return to the facility. Immediate action the facility took included, R1 was placed on 30-minute safety checks, all residents with WanderGuards were checked for functionality, including R1. All WanderGuards and door alarms were found to be in proper working order. Education was immediately sent out to all employees regarding WanderGuards use and turning off alarms. A facility policy titled WanderGuard Alert System dated 8/2025, indicated the purpose of the policy is to provide a safe/secure environment for our residents at risk for elopement through monitoring, by utilizing the WanderGuard Alert system. A facility policy titled Elopement - Long Term Care dated 5/2026, indicated the purpose of the policy is to provide guidance for staff in reviewing residents for risk for elopement and responding during potential elopement. Policy procedure included "It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical", and "Should an employee observe a resident leaving the premises, he/she should: attempt to prevent the departure if not otherwise approved; obtain assistance from other staff members in the immediate vicinity, if necessary; instruct another staff member to inform the charge nurse or Director of Nursing and/or the facility Administrator that a resident has left the premises; and be courteous in preventing the departure and in returning the resident to the facility. The past noncompliance immediate jeopardy began	F0689		

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F0689 SS = SQC-J	Continued from page 4 on 6/28/29. The immediate jeopardy was removed on 6/29/26 and the deficient practice corrected by 6/29/26, after the facility implemented a systemic plan that included the following actions: education for all employees regarding WanderGuard use and turning off alarms.	F0689		

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20000	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 7/7/26 to 7/8/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure requirements. The following complaint was reviewed H13303125C (3063442) Minnesota Department of Health (MDH) documents the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and	20000		

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20000	Continued from page 1 therefore a signature is not required at the bottom of the first page of state form.	20000		