Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2025

Administrator
Cura of Melrose
101 5th Avenue NW
Melrose, MN 56352

RE: CCN: 245396
Cycle Start Date: July 29, 2025

Dear Administrator:

On August 15, 2025, we notified you a remedy was imposed. On November 18, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 14, 2025.

As authorized by CMS the remedy of:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR §488.417(a), effective August 30, 2025, be discontinued as of November 14, 2025. (42 CFR 488.417 (b))

In our letter of August 15, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 30, 2025. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 20, 2025

Administrator
Cura of Melrose
101 5th Avenue NW
Melrose, MN 56352

Re: Reinspection Results
Event ID: 1D1F62-H2

Dear Administrator:

On September 15, 2025, 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 July 29, 2025. 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
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator
CURA OF MELROSE

101 5TH AVENUE NW
MELROSE, MN 56352

RE: CCN: 245396
Cycle Start Date: July 29, 2025

Dear Administrator:

On July 29, 2025, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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.

If you have not achieved substantial compliance by August 30, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

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 Operations Supervisor, 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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 29, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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

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Electronically delivered

August 15, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D1F62-H1

Dear Administrator:

The above facility was surveyed on July 29, 2025 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:

Annette Winters, Regional Operations Supervisor, 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

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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 7/24/25, 7/28/25 and 7/29/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53961008C (2567306) with deficiencies issued at F686 and F580. 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 that substantial compliance with the regulations has been attained.	F0000		08/15/2025
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F0580	R1s provider was contacted on 8/19/2025; reviewed residents current wound status, orders and skin and wound assessment. An audit will be conducted of current residents with wound assessments for accuracy of wound assessments, proper provider notification, and orders. The policy, Skin Integrity Maintenance and Pressure Injury Prevention, was reviewed. A checklist is available for use to assure all notifications are completed upon identification of a pressure ulcer. Licensed nurses will be educated on wound staging, proper notification to PCP, completion of the skin impairment/wound checklist, and wound UDA completion. The Director or Nursing and/or designee will conduct audits of residents with wounds to ensure the assessments are completed, PCP resident representatives are notified. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment	08/28/2025

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

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 07/29/2025

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
F0580 SS = D	Continued from page 1 treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's Admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress	F0580	Continued from page 1 as necessary.	

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 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	101 5TH AVENUE NW , MELROSE, Minnesota, 56352

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F0580 SS = D	Continued from page 2 disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated 6/6/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1’s skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. The document lacked evidence of the provider notification. R1’s skin assessment dated 6/30/25 at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1's treatment administration record (TAR) dated 6/20/25 through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to document an assessment of the pressure ulcer, measurements, or description from 6/20/25 through 7/14/25, during the time period the facility nursing staff was responsible for R1’s skin integrity. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress.	F0580		

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 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0580 SS = D	Continued from page 3 LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified the treatment team, the dietitian, and the provider. On 7/28/25 at 1:16 p.m., LPN-D stated she would update the provider, the nurse manager, and the family about a new skin impairment. LPN-D stated she was just monitoring R1's open skin area progress but she did not document its status during her skin assessment on 6/30/25 since it was not a new skin impairment. LPN-D stated usually the RNs will do an evaluation for stuff like that. She just made sure the Mepilex dressing was in place. 7/28/25 at 1:21 p.m., RN-B stated she did not document a description and measurement about the new skin impairment on 6/20/25, and did not notify the nurse manager or the provider. RN-B stated she initiated the task to monitor the open skin area at R1's coccyx and could not find any documentation about when it was resolved. On 7/28/25 at 3:12 p.m., a care coordinator, registered nurse (RN)-C stated she expected licensed nurses to describe and measure any new skin impairment, documented in the progress note, initiate a task for monitoring process, and notified the care coordinator and the provider. RN-C stated nursing staff did not notify the provider about R1's new skin impairment and could not find any documentation about when R1's resolved skin impairment prior to her hospitalization. RN-C stated R1 was back from hospital today and she sustained pressure ulcer at her coccyx area with 9.0 cm length, 8.2 cm width, and 0.7 cm depth with tunneling. On 7/29/25 at 11:38 a.m., RN-D from R1's medical team office stated she could not find any new skin impairment notification in their system about R1 from 6/20/25 through 7/14/25. RN-D stated she received the only notification about R1's wound status today on 7/29/25 and they ordered a wound care consult. On 7/29/25 at 12:34 p.m., the medical director (MD)-A stated he expected nursing staff to follow change in condition and wound care policies. MD-A stated nursing staff had to notify the provider about a new skin impairment depending on the resident diagnosis.	F0580		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	101 5TH AVENUE NW , MELROSE, Minnesota, 56352

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F0580 SS = D	Continued from page 4 On 7/29/25 at 3:34 p.m., the director of nursing (DON) stated she expected nursing staff to follow a change in condition policy about a new skin impairment finding. the DON stated she expected staff to report any resident wound concerns to the provider immediately. The DON stated with new skin impairment, nurses had to update the care team, record the measurement and the description of the wound, open a task to monitor its healing process, updated the dietary department, the care plan, the provider, and the family. The DON stated nursing staff did not update the nurse manager about R1's new skin impairment. The facility policy for Change in Condition dated 7/2025 directed nurses to make detailed observations and gather relevant and pertinent information for the provider of a change in the resident's condition. The policy also directed nurses to record in the resident's medical record information relative to changes in the resident's status and update to the resident's plan of care.	F0580		
F0686 SS = G	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 provide care consistent with professional standard of practice to prevent worsening of pressure ulcer identified on 6/20/25 for 1 of 3 residents (R1) reviewed when the facility failed to provide appropriate assessment and treatment. This resulted in actual harm to R1 when she was identified	F0686	R1 pressure ulcer was comprehensively assessed on 7/28/2025. R1s current wound status, orders were reviewed with R1s provider. 7/29/2025 wound consult ordered. An audit will be conducted of current residents with wound assessments for accuracy of wound assessments, proper provider notification, and treatment orders. Licensed nurses will be educated on wound staging, proper notification to PCP, completion of the skin impairment/wound checklist, and appropriate wound assessment and documentation and appropriately responding to and communication of resident refusals of wound care, interventions and assessment wound UDA completion. This will be completed by. Skin Evaluation (Initial/Weekly) UDA was updated and made live in PointClickCare. Change made to UDA included an automatic clinical alert that is sent to the dashboard for all new skin impairments noted within the UDA. The Director or Nursing and/or designee will conduct audits of residents with wounds to ensure the assessments are completed, PCP is aware, wound care orders are completed. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	08/28/2025

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 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	101 5TH AVENUE NW , MELROSE, Minnesota, 56352

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F0686 SS = G	Continued from page 5 with stage 3 pressure ulcer at coccyx area during admission at the hospital on 7/15/25. Findings include: According to the State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, revision 229, issued 4/25/25 a pressure ulcer and stage 3 pressure ulcer is defined as Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. On 7/29/25 at 10:09 a.m., during R1’s wound dressing observation, RN-G stated R1’s pressure ulcer measurements indicated the following: length: 5.5 cm; width: 3.5 cm; and depth: 1 cm. RN-G stated he noted an excoriation around the wound, blanchable, little slough, borderline stage 3 pressure ulcer. R1's Admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility,	F0686		

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F0686 SS = G	Continued from page 6 and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated 6/6/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1’s skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. R1’s care plan review lacked evidence of the focus, goal and interventions reviewed after the new skin impairment finding on 6/20/25. Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to document an assessment of the pressure ulcer, measurements, or description from 6/20/25 through 7/14/25, during the time the facility nursing staff was responsible for R1’s skin integrity. R1's treatment administration record (TAR) dated 6/20/25, through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. R1’s skin assessment dated 6/30/25 at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1’s skin assessment and progress notes 7/7/25 and 7/14/25, lacked documentation of R1’s pressure ulcer of the coccyx area. On 7/15/25 at 6:33 p.m., a progress note indicated R1 was very drowsy/lethargic all shift with blood pressure of 62/42 and nursing staff sent R1 to the hospital for	F0686		

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F0686 SS = G	Continued from page 7 further evaluation per provider order. On 7/15/25, an emergency department (ED) provider note indicated emergency medical services (EMS) brought R1 to the hospital for evaluation of low blood pressures, increased fatigue, increased weakness, and some disorientation. The note also indicated a discrepancy in the history from the nursing home staff and there was very minimal documentation in the chart. R1's MDS dated 7/15/25 indicated no unhealed pressure ulcer/pressure injury identified. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress. LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified the treatment team, the dietitian, and the provider. On 7/24/25 at 3:32 p.m., LPN-B stated it was the standard of practice to check the status of an existing skin impairment compared to the initial assessment during the skin assessment and documented whether it was getting better or worse. LPN-B stated with a resolved skin impairment, nursing staff had to document it in the progress note and notified the nursing manager. On 7/28/25 at 8:54 a.m., LPN-C stated she reviewed the assessment of the week before her shift and looked at the areas of concerns, documented any findings in the progress note, and notified the care manager and the provider. On 7/28/25 at 11:54 a.m., a registered nurse (RN)-A stated ED provider note on 7/16/25 indicated R1 had sacral pressure ulcer present at the admission. RN-A stated a hospital wound nurse who was consulted to see R1 evaluated R1's sacral pressure ulcer to be at least stage III with 9 cm length and 7 cm width and was unable to determine the depth. On 7/28/25 at 1:16 p.m., LPN-D stated she would update	F0686		

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F0686 SS = G	Continued from page 8 the provider, the nurse manager, and the family about a new skin impairment. LPN-D stated she was just monitoring R1's open skin area progress but she did not document its status during her skin assessment on 6/30/25 since it was not a new skin impairment. LPN-D stated usually the RNs will do an evaluation for stuff like that. She just made sure the Mepilex dressing was in place. On 7/28/25 at 1:21 p.m., RN-B stated she did not document a description and measurement about R1's new skin impairment on 6/20/25, and did not notify the nurse manager or the provider. RN-B stated she initiated the task to monitor the open skin area at R1's coccyx and could not find any documentation about when it was resolved. On 7/28/25 at 3:12 p.m., a care coordinator, registered nurse (RN)-C stated she expected licensed nurses to describe and measure any new skin impairment, documented in the progress note, initiated a task for monitoring process, and notified the care coordinator and the provider. RN-C stated nursing staff did not notify the provider about R1's new skin impairment. RN-C stated she could not find any documentation about R1's resolved skin impairment prior to her hospitalization. RN-C stated R1 was back from hospital today and she sustained pressure ulcer at her coccyx area with 9.0 cm length, 8.2 cm width, and 0.7 cm depth with tunneling. On 7/29/25 at 10:09 a.m., during R1's wound dressing observation, RN-G stated R1's pressure ulcer measurements indicated the following: length: 5.5 cm; width: 3.5 cm; and depth: 1 cm. RN-G stated he noted an excoriation around the wound, blanchable, little slough, borderline stage III pressure ulcer. On 7/29/25 at 10:42 a.m., R1 stated the sore at her bottom was there for a little bit before she went to the hospital. R1 stated it hurt sometimes but she did not have pain at this time. R1 stated she could not remember what happened before she left for hospital. R1 stated she did not sleep in bed before her hospitalization, she preferred to sleep in her recliner. On 7/29/25 at 11:38 a.m., RN-D from R1's medical team office stated she could not find any new skin	F0686		

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F0686 SS = G	Continued from page 9 impairment notification in their system about R1 from 6/20/25 through 7/14/25. RN-D stated she received the only notification about R1's wound status today on 7/29/25 and they ordered a wound care consult. On 7/29/25 at 12:07 p.m., RN-E stated she assessed R1 when she came to the intensive care unit (ICU) for septic shock. RN-E stated the only reason she made the report to the State Agency (SA) was the skin impairment. RN-E stated R1 had a massive open skin area which looked like a pressure ulcer at her sacral area. On 7/29/25 at 12:09 p.m., a nursing assistant (NA)-A stated during the week when R1 went to the hospital, she reported a purple bluish bruising around R1's coccyx area to RN-F who looked at it but when she came back the next day, she could not find any documentations about the bruising. On 7/29/25 at 12:34 p.m., the medical director (MD)-A stated he expected nursing staff to follow change in condition and wound care policies. MD-A stated nursing staff had to notify the provider about a new skin impairment depending on the resident diagnosis. On 7/29/25 at 1:32 p.m., RN-F stated nurses had to report any new skin impairments to the case manager, the provider, and the family. RN-F stated nurses had to document the size, characteristics, status of an existing skin impairment or reopened, and initiated a risk management if the case manager wanted to do more investigation. RN-F did not recall getting a report from nursing staff about R1's coccyx area condition. On 7/29/25 at 3:34 p.m., the director of nursing (DON) stated she expected nursing staff to follow a change in condition and wound care policies about a new skin impairment finding. The DON stated with new skin impairment, nurses had to update the care team, record the measurement and the description of the wound, open a task to monitor its healing process, updated the dietary department, the care plan, the provider, and the family. The DON stated she could not find any care plan updated about R1's new skin impairment finding on 6/20/25. The DON stated she could not find any documentations about when R1's open skin area at her coccyx was resolved. Nursing staff did not update the nurse manager about R1's new skin impairment and staff failed to implement a pressure reduction cushion in the	F0686		

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F0686 SS = G	Continued from page 10 recliner for R1. The DON stated the professional standard of practice would be to describe and measure the wound, documented in the progress note, update the care team and the provider, initiated offload pressure reduction measures, and follow the provider recommendation. The facility policy for Change in Condition dated 7/2025 directed nurses to make detailed observations and gather relevant and pertinent information for the provider of a change in the resident's condition. The policy also directed nurses to record in the resident's medical record information relative to changes in the resident's status and update to the resident's plan of care. The facility Wound Care policy dated 1/2025 directed nurses to follow the professional standards of practice, to observe the wound and surrounding skin taking note of the appearance of the wound bed, surrounding skin, edema, redness, drainage, indications of wound status. The policy also indicated to notify the supervisor if the resident refuses the wound care.	F0686		

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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 7/24/25, 7/28/25 and 7/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT compliance with the MN State Licensure. The following complaint was reviewed: H53961008C (2567306) with a licensing orders were issued at (0900) and (265).	20000		08/15/2025

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

Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	20265	R1s provider was contacted on 8/19/2025; reviewed residents current wound status, orders and skin and wound assessment. An audit will be conducted of current residents with wound assessments for accuracy of wound assessments, proper provider notification, and orders. The policy, Skin Integrity Maintenance and Pressure Injury Prevention, was reviewed. A checklist is available for use to assure all notifications are completed upon identification of a pressure ulcer. Licensed nurses will be educated on wound staging, proper notification to PCP, completion of the skin impairment/wound checklist, and wound UDA completion. The Director or Nursing and/or designee will conduct audits of residents with wounds to ensure the assessments are completed, PCP resident representatives are notified. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	08/28/2025

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20265	Continued from page 2 failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's Admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated 6/6/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1’s skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. The document lacked evidence of the provider notification. R1’s skin assessment dated 6/30/25 at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1's treatment administration record (TAR) dated 6/20/25 through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. Review of R1's medical record including skin assessments and progress notes, indicated the facility	20265		

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20265	Continued from page 3 failed to document an assessment of the pressure ulcer, measurements, or description from 6/20/25 through 7/14/25, during the time period the facility nursing staff was responsible for R1's skin integrity. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress. LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified the treatment team, the dietitian, and the provider. On 7/28/25 at 1:16 p.m., LPN-D stated she would update the provider, the nurse manager, and the family about a new skin impairment. LPN-D stated she was just monitoring R1's open skin area progress but she did not document its status during her skin assessment on 6/30/25 since it was not a new skin impairment. LPN-D stated usually the RNs will do an evaluation for stuff like that. She just made sure the Mepilex dressing was in place. 7/28/25 at 1:21 p.m., RN-B stated she did not document a description and measurement about the new skin impairment on 6/20/25, and did not notify the nurse manager or the provider. RN-B stated she initiated the task to monitor the open skin area at R1's coccyx and could not find any documentation about when it was resolved. On 7/28/25 at 3:12 p.m., a care coordinator, registered nurse (RN)-C stated she expected licensed nurses to describe and measure any new skin impairment, documented in the progress note, initiate a task for monitoring process, and notified the care coordinator and the provider. RN-C stated nursing staff did not notify the provider about R1's new skin impairment and could not find any documentation about when R1's resolved skin impairment prior to her hospitalization. RN-C stated R1 was back from hospital today and she sustained pressure ulcer at her coccyx area with 9.0 cm length, 8.2 cm width, and 0.7 cm depth with tunneling. On 7/29/25 at 11:38 a.m., RN-D from R1's medical team office stated she could not find any new skin impairment notification in their system about R1 from	20265		

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20265	Continued from page 4 6/20/25 through 7/14/25. RN-D stated she received the only notification about R1's wound status today on 7/29/25 and they ordered a wound care consult. On 7/29/25 at 12:34 p.m., the medical director (MD)-A stated he expected nursing staff to follow change in condition and wound care policies. MD-A stated nursing staff had to notify the provider about a new skin impairment depending on the resident diagnosis. On 7/29/25 at 3:34 p.m., the director of nursing (DON) stated she expected nursing staff to follow a change in condition policy about a new skin impairment finding. the DON stated she expected staff to report any resident wound concerns to the provider immediately. The DON stated with new skin impairment, nurses had to update the care team, record the measurement and the description of the wound, open a task to monitor its healing process, updated the dietary department, the care plan, the provider, and the family. The DON stated nursing staff did not update the nurse manager about R1's new skin impairment. The facility policy for Change in Condition dated 7/2025 directed nurses to make detailed observations and gather relevant and pertinent information for the provider of a change in the resident's condition. The policy also directed nurses to record in the resident's medical record information relative to changes in the resident's status and update to the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure timely notification to the physician. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3	20900	R1 pressure ulcer was comprehensively assessed on 7/28/2025. R1s current wound status, orders were reviewed with R1s provider. 7/29/2025 wound consult	08/28/2025

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20900	Continued from page 5 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide care consistent with professional standard of practice to prevent worsening of pressure ulcer identified on 6/20/25 for 1 of 3 residents (R1) reviewed when the facility failed to provide appropriate assessment and treatment. This resulted in actual harm to R1 when she was identified with stage 3 pressure ulcer at coccyx area during admission at the hospital on 7/15/25. Findings include: According to the State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, revision 229, issued 4/25/25 a pressure ulcer and stage 3 pressure ulcer is defined as Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the	20900	Continued from page 5 ordered. An audit will be conducted of current residents with wound assessments for accuracy of wound assessments, proper provider notification, and treatment orders. Licensed nurses will be educated on wound staging, proper notification to PCP, completion of the skin impairment/wound checklist, and appropriate wound assessment and documentation and appropriately responding to and communication of resident refusals of wound care, interventions and assessment wound UDA completion. This will be completed by. Skin Evaluation (Initial/Weekly) UDA was updated and made live in PointClickCare. Change made to UDA included an automatic clinical alert that is sent to the dashboard for all new skin impairments noted within the UDA. The Director or Nursing and/or designee will conduct audits of residents with wounds to ensure the assessments are completed, PCP is aware, wound care orders are completed. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

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20900	Continued from page 6 depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. On 7/29/25 at 10:09 a.m., during R1’s wound dressing observation, RN-G stated R1’s pressure ulcer measurements indicated the following: length: 5.5 cm; width: 3.5 cm; and depth: 1 cm. RN-G stated he noted an excoriation around the wound, blanchable, little slough, borderline stage 3 pressure ulcer. R1's Admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated 6/6/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1’s skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. R1’s care plan review lacked evidence of the focus, goal and interventions reviewed after the new skin impairment finding on 6/20/25. Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to document an assessment of the pressure ulcer,	20900		

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20900	Continued from page 7 measurements, or description from 6/20/25 through 7/14/25, during the time the facility nursing staff was responsible for R1's skin integrity. R1's treatment administration record (TAR) dated 6/20/25, through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. R1's skin assessment dated 6/30/25 at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1's skin assessment and progress notes 7/7/25 and 7/14/25, lacked documentation of R1's pressure ulcer of the coccyx area. On 7/15/25 at 6:33 p.m., a progress note indicated R1 was very drowsy/lethargic all shift with blood pressure of 62/42 and nursing staff sent R1 to the hospital for further evaluation per provider order. On 7/15/25, an emergency department (ED) provider note indicated emergency medical services (EMS) brought R1 to the hospital for evaluation of low blood pressures, increased fatigue, increased weakness, and some disorientation. The note also indicated a discrepancy in the history from the nursing home staff and there was very minimal documentation in the chart. R1's MDS dated 7/15/25 indicated no unhealed pressure ulcer/pressure injury identified. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress. LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified the treatment team, the dietitian, and the provider.	20900		

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20900	Continued from page 8 On 7/24/25 at 3:32 p.m., LPN-B stated it was the standard of practice to check the status of an existing skin impairment compared to the initial assessment during the skin assessment and documented whether it was getting better or worse. LPN-B stated with a resolved skin impairment, nursing staff had to document it in the progress note and notified the nursing manager. On 7/28/25 at 8:54 a.m., LPN-C stated she reviewed the assessment of the week before her shift and looked at the areas of concerns, documented any findings in the progress note, and notified the care manager and the provider. On 7/28/25 at 11:54 a.m., a registered nurse (RN)-A stated ED provider note on 7/16/25 indicated R1 had sacral pressure ulcer present at the admission. RN-A stated a hospital wound nurse who was consulted to see R1 evaluated R1's sacral pressure ulcer to be at least stage III with 9 cm length and 7 cm width and was unable to determine the depth. On 7/28/25 at 1:16 p.m., LPN-D stated she would update the provider, the nurse manager, and the family about a new skin impairment. LPN-D stated she was just monitoring R1's open skin area progress but she did not document its status during her skin assessment on 6/30/25 since it was not a new skin impairment. LPN-D stated usually the RNs will do an evaluation for stuff like that. She just made sure the Mepilex dressing was in place. On 7/28/25 at 1:21 p.m., RN-B stated she did not document a description and measurement about R1's new skin impairment on 6/20/25, and did not notify the nurse manager or the provider. RN-B stated she initiated the task to monitor the open skin area at R1's coccyx and could not find any documentation about when it was resolved. On 7/28/25 at 3:12 p.m., a care coordinator, registered nurse (RN)-C stated she expected licensed nurses to describe and measure any new skin impairment, documented in the progress note, initiated a task for monitoring process, and notified the care coordinator and the provider. RN-C stated nursing staff did not notify the provider about R1's new skin impairment. RN-C stated she could not find any documentation about	20900		

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20900	Continued from page 9 R1's resolved skin impairment prior to her hospitalization. RN-C stated R1 was back from hospital today and she sustained pressure ulcer at her coccyx area with 9.0 cm length, 8.2 cm width, and 0.7 cm depth with tunneling. On 7/29/25 at 10:09 a.m., during R1's wound dressing observation, RN-G stated R1's pressure ulcer measurements indicated the following: length: 5.5 cm; width: 3.5 cm; and depth: 1 cm. RN-G stated he noted an excoriation around the wound, blanchable, little slough, borderline stage III pressure ulcer. On 7/29/25 at 10:42 a.m., R1 stated the sore at her bottom was there for a little bit before she went to the hospital. R1 stated it hurt sometimes but she did not have pain at this time. R1 stated she could not remember what happened before she left for hospital. R1 stated she did not sleep in bed before her hospitalization, she preferred to sleep in her recliner. On 7/29/25 at 11:38 a.m., RN-D from R1's medical team office stated she could not find any new skin impairment notification in their system about R1 from 6/20/25 through 7/14/25. RN-D stated she received the only notification about R1's wound status today on 7/29/25 and they ordered a wound care consult. On 7/29/25 at 12:07 p.m., RN-E stated she assessed R1 when she came to the intensive care unit (ICU) for septic shock. RN-E stated the only reason she made the report to the State Agency (SA) was the skin impairment. RN-E stated R1 had a massive open skin area which looked like a pressure ulcer at her sacral area. On 7/29/25 at 12:09 p.m., a nursing assistant (NA)-A stated during the week when R1 went to the hospital, she reported a purple bluish bruising around R1's coccyx area to RN-F who looked at it but when she came back the next day, she could not find any documentations about the bruising. On 7/29/25 at 12:34 p.m., the medical director (MD)-A stated he expected nursing staff to follow change in condition and wound care policies. MD-A stated nursing staff had to notify the provider about a new skin impairment depending on the resident diagnosis.	20900		

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20900	Continued from page 10 On 7/29/25 at 1:32 p.m., RN-F stated nurses had to report any new skin impairments to the case manager, the provider, and the family. RN-F stated nurses had to document the size, characteristics, status of an existing skin impairment or reopened, and initiated a risk management if the case manager wanted to do more investigation. RN-F did not recall getting a report from nursing staff about R1's coccyx area condition. On 7/29/25 at 3:34 p.m., the director of nursing (DON) stated she expected nursing staff to follow a change in condition and wound care policies about a new skin impairment finding. The DON stated with new skin impairment, nurses had to update the care team, record the measurement and the description of the wound, open a task to monitor its healing process, updated the dietary department, the care plan, the provider, and the family. The DON stated she could not find any care plan updated about R1's new skin impairment finding on 6/20/25. The DON stated she could not find any documentations about when R1's open skin area at her coccyx was resolved. Nursing staff did not update the nurse manager about R1's new skin impairment and staff failed to implement a pressure reduction cushion in the recliner for R1. The DON stated the professional standard of practice would be to describe and measure the wound, documented in the progress note, update the care team and the provider, initiated offload pressure reduction measures, and follow the provider recommendation. The facility policy for Change in Condition dated 7/2025 directed nurses to make detailed observations and gather relevant and pertinent information for the provider of a change in the resident's condition. The policy also directed nurses to record in the resident's medical record information relative to changes in the resident's status and update to the resident's plan of care. The facility Wound Care policy dated 1/2025 directed nurses to follow the professional standards of practice, to observe the wound and surrounding skin taking note of the appearance of the wound bed, surrounding skin, edema, redness, drainage, indications of wound status. The policy also indicated to notify the supervisor if the resident refuses the wound care.	20900		

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20900	Continued from page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and procedures, educate staff, and implement measures to ensure residents are receiving the necessary services to prevent pressure ulcers or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care, to ensure appropriate care and services are implemented to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		