Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 17, 2026

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

RE: CCN: 245396
Cycle Start Date: December 4, 2025

Dear Administrator:

On January 26, 2026, we notified you a remedy was imposed.

On February 12, 2026, 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 February 3, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 10, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 26, 2026, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 3, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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

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February 17, 2026

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

Re: Reinspection Results
Event ID: 1E0DF6-H1

Dear Administrator:

On February 12, 2026, 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 January 14, 2026. 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2026

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

RE: CCN: 245396
Cycle Start Date: December 4, 2025

Dear Administrator:

On December 29, 2025, we informed you of imposed enforcement remedies.

On January 14, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F609 D, F689 G

In addition, at the time of this survey/revisit, we identified the following deficiencies:

F656 D, F689 G

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 10, 2026.

This Department continues to recommend that CMS impose a 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.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2026.

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.

As we notified you in our letter of December 29, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 4, 2026.

However, due to the extended survey the new NATCEP loss date is February 10, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

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Electronically delivered

January 26, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1E0DF6-H1

Dear Administrator:

The above facility survey was completed on January 14, 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 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.

P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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
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 1/9/26 through 1/14/26, a complaint 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. The following complaint was reviewed during the survey. H53961621C (2695040) with a licensing order issued at 0830.	20000		01/30/2026

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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CURA OF MELROSE	**101 5TH AVENUE NW , MELROSE, Minnesota, 56352**

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20000	Continued from page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to protect 1 of 4 residents (R1) from avoidable accidents when care plan interventions were not implemented. This resulted in actual harm to R1 who fell out of a recliner and sustained a large hematoma (a solid swelling of clotted blood) and laceration to the front of her head. Findings include: R1's Admission Record indicated she admitted to the facility 8/26/24. R1's diagnosis included dementia, depression, overactive bladder and osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 11/17/25, identified intact cognition and indicated she required substantial to maximal assistance for transfers and toileting. R1's care plan revised 12/19/25, identified a potential for injury related to a history of falls. Interventions included: signage in room, appropriate footwear and grip strips in room. The care plan identified a potential for injury related to a history of electric recliner use. The care plan indicated R1 sustained a fall from a lift recliner when operating the remote control independently on 12/16/25. The cord for the recliner was removed from the room. The care plan indicated the following interventions: 11/19/24, electric lift recliner: stationary only. Per therapy	20830	Corrected.	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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20830	Continued from page 2 recommendation keep recliner unplugged to promote resident safety. The care plan indicated R1 was non-ambulatory and required the use of a mechanical stand device for transfers. R1's Kardex (care guide) dated 12/1/25, indicated, per therapy staff, keep recliner unplugged to promote resident safety. R1's incident reports and correlating Post-Fall Investigations identified the following: R1 incident report dated 5/29/25, indicated she was found face down on her wheelchair leg, on the floor in front of her recliner. The recliner was in the highest position, and it appeared R1 was attempting to self-transfer. Post-Fall Investigation dated 5/29/25, indicated Prior to fall, R1 was last observed resting in her recliner. R1 appeared to have attempted to self-transfer as recliner was in the highest position. Immediate intervention was to unplug the recliner for the night. New intervention indicated recliner to remain unplugged, however, R1's care plan dated 11/19/24, indicated recliner was not to be plugged in. R1's incident report dated 12/16/25, indicated staff were alerted R1 was on the floor face first, with pooling blood on the ground. R1 had her hands on her head trying to cover her forehead which filled her hands with blood. R1 had been last observed in her recliner and recliner was in the highest position at the time of the fall. R1 had a large hematoma on her forehead along with a skin tear. R1 also complained of pain to her right elbow. R1 was transferred to the emergency department (ED). Post Fall Investigation dated 12/16/25, indicated R1 had been resting in her recliner after lunch. R1 fell and hit her face on the ground after attempting to self-transfer from the recliner. R1's care plan reflected recliner to remain unplugged, care plan had not been followed. R1's ED Provider Note indicated R1 presented to the ED after she tried to get out of her lift chair in the nursing home and mis-stepped and fell forward onto her head. It sounded like she was non-ambulatory at baseline, but someone had her lift chair plugged in and so she tried to lift this up and tried to walk which was when she fell. She had no dizziness or lightheadedness that preceded the event, so it was a	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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20830	Continued from page 3 mechanical fall. R1 reported some left hip pain as well as right elbow pain and some mild neck pain. She reported a headache as well, especially overlying the large hematoma on the frontal region. R1's Progress Notes indicated the following: 12/16/25, Staff immediately paged an ambulance. Writer entered the room to see three staff present and nurse assessing resident for injuries. Writer noted recliner in high position and asked if it had been moved when staff responded to the fall. They stated no. Verified sticky notes in place on both sides of the cord indicating not to be plugged in per therapy. 12/16/25, Resident returned from ED at 6:30 p.m. R1 was transferred into bed as she was sleepy due to administration of hydromorphone in the ED. Cares completed along with skin check. No changes to skin besides the hematoma to right elbow and right forehead. Swelling was reduced from when she left to the ED and bruising is noted. Skin tear was scabbed and no longer bleeding. 12/17/25, Bruising to right eye forming, swelling and hematoma. 12/17/25, Noted that care plan had not been followed in relation to recliner to remain unplugged. Labels remain in place to cord and battery that indicated for the chair to not be plugged in. During observation and interview on 1/9/26 at 9:37 a.m., R1 was seated in a wheelchair in her room. R1 had a fading bruise on her forehead. R1 said, "I'm not good." I don't like being in this chair with the table in front of it. R1 said someone told her there was something wrong with her recliner so she could not sit in it. R1 stated she remembered falling from the recliner chair and said she was trying to go to bed. R1 said she usually asked for help but did not know if she had that day, then said she probably had not. R1 stated she got hurt and had a bruise on her head. A sign on R1's recliner said, resident do not sit. At 11:20 a.m., R1 remained seated in her wheelchair and appeared to be asleep. R1 had one foot on a foot pedal and the other foot was on the floor. R1 had regular socks on her feet, no anti slip footwear.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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20830	Continued from page 4 During interview on 1/9/25 at 11:47 a.m., NA-A stated the staff carried iPads with the Kardex for each resident on it. The Kardex was viewed with NA-A and indicated stationary chair, wheelchair stored in bathroom. The Kardex did not identify appropriate footwear. During interview on 1/9/26 at 12:01 p.m., registered nurse (RN)-A confirmed R1 was wearing nylon stockings that were not anti-slip. RN-A said R1 had some cognitive impairment and said most of R1's falls had been related to doing things she would have been safer to have staff assistance with. RN-A said fall interventions included signs, toileting assistance and getting her up early. RN-A said the most recent fall occurred because someone had plugged R1's recliner in and said it may have been staff or family. RN-A said if family plugged in the chair that was not something staff would have looked for. RN-A said appropriate footwear would include grip socks or non-slip footwear. During interview on 1/13/25 at 4:23 p.m., family member (FM)-A stated when R1 fell the lift chair was operational and R1 raised herself up. FM-A said the chair was not supposed to be plugged in. FM-A said a family member may have plugged in the recliner when they visited but said none of R1's family members had visited FM-A the day she fell. FM-A said it was not the first or even the second time R1 had fallen from the recliner. FM-A said R1 had declined cognitively and physically and would not have been able to plug the chair in by herself. During interview on 1/13/25 at 4:47 p.m., NA-B said, the day R1 fell, she had been coming out of another room and had been alerted by a hospice nurse that R1 was on the floor. NA-B said when she last saw R1, she was in the recliner asleep but could not remember if her feet were up or not. NA-B said when she found R1 she was face down in front of the recliner and said there was a lot of blood. NA-B said she was aware the recliner was not supposed to be plugged in due to previous falls but said she never thought to check to see if it was plugged in because she assumed no one would have plugged it in. NA-B said she was sure both family and staff had plugged in R1's recliner chair. During interview on 1/14/26 at 10:26 a.m., RN-B stated	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/14/2026**

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CURA OF MELROSE	**101 5TH AVENUE NW , MELROSE, Minnesota, 56352**

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20830	Continued from page 5 R1 had had more than one fall from the recliner and said the care plan had been updated to include leaving the chair unplugged in November of 2024. RN-B said she was not sure how the chair was getting plugged in but said if staff saw R1 in the recliner with her feet up they should have checked to make sure it was not plugged in. During interview on 1/14/26 at 10:45 p.m., the interim director of nursing (DON) stated R1 had multiple falls from the recliner and said it was care planned that the chair was not supposed to be plugged in. The interim DON said staff should have been checking to ensure the chair was unplugged and said the recliner was only to be used as a stationary chair. Facility Policy Using the Care Plan dated 1/2026, indicated the care plan shall be used to develop the residents daily care routines and be available to staff who have responsibility for providing care. The Kardex will be comprised of interventions from the care plan. Health care personnel are responsible for following the residents care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls to ensure interventions are being implemented. The DON or designee could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		

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 01/14/2026

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F0000	INITIAL COMMENTS On 1/9/26 through 1/14/26, 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. H53961621C (2695040) with a deficiency cited at F689. As a result of the investigation as deficiency was also issued at F656. 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		01/30/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F0656	R4's care plan was reviewed and revised to indicate that hot beverages should be cooled with ice cube/water. An audit will be conducted for all current residents with a known risk for potential injury from hot liquids to assure appropriate interventions are in place. Audits will then be initiated to assure those interventions are implemented. Nursing staff will be educated on the importance of following resident care plan interventions, including interventions for reducing the risk for injury from hot liquids. The facility will conduct audits to assure that care planned interventions for reducing the risk of potential injury from hot liquids is being implemented. Audits will be completed twice a week for four weeks	02/03/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0656 SS = D	Continued from page 1 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: The facility failed to implement care planned interventions to reduce the risk for burns for 1 of 4 residents reviewed (R4) who spilled hot coffee on herself. R4's Admission Record indicated she admitted to the facility on 5/20/21. Diagnosis included parkinsonism, depression, anxiety and dementia. R4's care plan dated 12/11/25 identified intact cognition and indicated she was able to eat independently. The care plan identified a risk for altered nutritional status and directed staff to provide covered mugs for hot liquids outside the dining	F0656	Continued from page 1 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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F0656 SS = D	Continued from page 2 room. R4's Hot Liquid Safety Evaluation dated 9/19/25, indicated temperature of liquid not to exceed 180 degrees. The evaluation indicated R4 had an isolated event on 9/16/2025, follow up completed on 9/17/2025. Standard temperature of hot liquid supplied by facility was less than 180 degrees. No additional interventions indicated at this time, see progress note on 9/17/25. R4's Progress Notes indicated the following: 9/17/25, Discussed with R4 the coffee spill from the previous day. R4 indicated she was watching television and when she set her cup down, she was not looking and it fell onto her lap. R4 said she would be more careful and said the coffee was "luke warm" at best. Isolated event. 12/10/25, A pink/red area on left inner thigh measured 10 centimeters CM) x 6 cm and pink/red area on right inner thigh 13 cm x 3 cm. Areas are warm to touch and R4 reported they were tender. Cause indicated R4 spilled coffee in her lap. Staff to put covers on hot liquids when she took them outside the dining room. 12/11/25, Interdisciplinary team review, upon investigation, R4 was attending an activity where a movie was being watched. Coffee was served per preference. R4 was in control of the mug at the time she accidently spilled into her lap. Skin was immediately assessed. Care plan was updated to reflect the use of covered mugs when resident is consuming hot beverages outside of the dining room. During observation on 1/14/26 at 9:02 a.m., R4 was seated in a wheelchair in her room working on a puzzle. R4 had a coffee cup in front of her with no lid. R4 sated she just got the coffee and said it was nice and hot. R4 said the only reason she had spilled her coffee in the past was because she hit it with her elbow. She said ever since she was supposed to have a lid but said staff had not given her one. During interview on 1/14/25 at 9:08 am., NA-C said R4 liked to have coffee in her room and said she believed R4 was supposed to have a cover on the mug.	F0656		

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F0656 SS = D	Continued from page 3 During interview on 1/14/26 at 10:26 a.m., RN-B stated R4 had an isolated incident when she spilled in her room because she was not paying attention. RN-B said when R4 was not in the dining room she was supposed to have covered cups. During interview on 1/14/26 at 10:45 a.m., the interim director of nursing stated R4 should have a cover on her cup as directed in the care plan. Facility Policy Using the Care Plan dated 1/2026, indicated the care plan shall be used to develop the residents daily care routines and be available to staff who have responsibility for providing care. The Kardex will be comprised of interventions from the care plan. Health care personnel are responsible for following the residents care plan.	F0656		
F0689 SS = G	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 observation, interview and document review the facility failed to protect 1 of 4 residents (R1) from avoidable accidents when care plan interventions were not implemented. This resulted in actual harm to R1 who fell out of a recliner and sustained a large hematoma (a solid swelling of clotted blood) and laceration to the front of her head. Findings include: R1's Admission Record indicated she admitted to the facility 8/26/24. R1's diagnosis included dementia, depression, overactive bladder and osteoporosis.	F0689	Following the fall on 12/16/25, R1's care plan was updated on 12/17/25 indicating the chair should not be used and again on 12/19/25 when the power cord was removed allowing the chair to only function as a stationary recliner. An audit will be conducted for all current residents deemed inappropriate for electric lift recliner/chair use, verifying that electrical cords have been removed from the device or the chair removed from use. Audits will then be initiated to assure interventions are implemented. Re-education with nursing staff was initiated 12/17/25 reminding staff of the important of following the resident's care plan and that electric lift recliners need to be assessed and that if the resident is unsafe to use it that it should be removed from use or have the power source removed from the chair. Nursing staff will receive additional reeducation on following resident care plan interventions. The facility will conduct audits to assure that care planned interventions for accidents/falls have been reviewed and have been implemented. 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.	02/03/2026

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F0689 SS = G	Continued from page 4 R1's quarterly Minimum Data Set (MDS) dated 11/17/25, identified intact cognition and indicated she required substantial to maximal assistance for transfers and toileting. R1's care plan revised 12/19/25, identified a potential for injury related to a history of falls. Interventions included: signage in room, appropriate footwear and grip strips in room. The care plan identified a potential for injury related to a history of electric recliner use. The care plan indicated R1 sustained a fall from a lift recliner when operating the remote control independently on 12/16/25. The cord for the recliner was removed from the room. The care plan indicated the following interventions: 11/19/24, electric lift recliner: stationary only. Per therapy recommendation keep recliner unplugged to promote resident safety. The care plan indicated R1 was non-ambulatory and required the use of a mechanical stand device for transfers. R1's Kardex (care guide) dated 12/1/25, indicated, per therapy staff, keep recliner unplugged to promote resident safety. R1's incident reports and correlating Post-Fall Investigations identified the following: R1 incident report dated 5/29/25, indicated she was found face down on her wheelchair leg, on the floor in front of her recliner. The recliner was in the highest position, and it appeared R1 was attempting to self-transfer. Post-Fall Investigation dated 5/29/25, indicated Prior to fall, R1 was last observed resting in her recliner. R1 appeared to have attempted to self-transfer as recliner was in the highest position. Immediate intervention was to unplug the recliner for the night. New intervention indicated recliner to remain unplugged, however, R1's care plan dated 11/19/24, indicated recliner was not to be plugged in. R1's incident report dated 12/16/25, indicated staff were alerted R1 was on the floor face first, with pooling blood on the ground. R1 had her hands on her head trying to cover her forehead which filled her hands with blood. R1 had been last observed in her recliner and recliner was in the highest position at	F0689		

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F0689 SS = G	Continued from page 5 the time of the fall. R1 had a large hematoma on her forehead along with a skin tear. R1 also complained of pain to her right elbow. R1 was transferred to the emergency department (ED). Post Fall Investigation dated 12/16/25, indicated R1 had been resting in her recliner after lunch. R1 fell and hit her face on the ground after attempting to self-transfer from the recliner. R1's care plan reflected recliner to remain unplugged, care plan had not been followed. R1's ED Provider Note indicated R1 presented to the ED after she tried to get out of her lift chair in the nursing home and mis-stepped and fell forward onto her head. It sounded like she was non-ambulatory at baseline, but someone had her lift chair plugged in and so she tried to lift this up and tried to walk which was when she fell. She had no dizziness or lightheadedness that preceded the event, so it was a mechanical fall. R1 reported some left hip pain as well as right elbow pain and some mild neck pain. She reported a headache as well, especially overlying the large hematoma on the frontal region. R1's Progress Notes indicated the following: 12/16/25, Staff immediately paged an ambulance. Writer entered the room to see three staff present and nurse assessing resident for injuries. Writer noted recliner in high position and asked if it had been moved when staff responded to the fall. They stated no. Verified sticky notes in place on both sides of the cord indicating not to be plugged in per therapy. 12/16/25, Resident returned from ED at 6:30 p.m. R1 was transferred into bed as she was sleepy due to administration of hydromorphone in the ED. Cares completed along with skin check. No changes to skin besides the hematoma to right elbow and right forehead. Swelling was reduced from when she left to the ED and bruising is noted. Skin tear was scabbed and no longer bleeding. 12/17/25, Bruising to right eye forming, swelling and hematoma. 12/17/25, Noted that care plan had not been followed in relation to recliner to remain unplugged. Labels remain in place to cord and battery that indicated for the	F0689		

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F0689 SS = G	Continued from page 6 chair to not be plugged in. During observation and interview on 1/9/26 at 9:37 a.m., R1 was seated in a wheelchair in her room. R1 had a fading bruise on her forehead. R1 said, "I'm not good." I don't like being in this chair with the table in front of it. R1 said someone told her there was something wrong with her recliner so she could not sit in it. R1 stated she remembered falling from the recliner chair and said she was trying to go to bed. R1 said she usually asked for help but did not know if she had that day, then said she probably had not. R1 stated she got hurt and had a bruise on her head. A sign on R1's recliner said, resident do not sit. At 11:20 a.m., R1 remained seated in her wheelchair and appeared to be asleep. R1 had one foot on a foot pedal and the other foot was on the floor. R1 had regular socks on her feet, no anti slip footwear. During interview on 1/9/25 at 11:47 a.m., NA-A stated the staff carried iPads with the Kardex for each resident on it. The Kardex was viewed with NA-A and indicated stationary chair, wheelchair stored in bathroom. The Kardex did not identify appropriate footwear. During interview on 1/9/26 at 12:01 p.m., registered nurse (RN)-A confirmed R1 was wearing nylon stockings that were not anti-slip. RN-A said R1 had some cognitive impairment and said most of R1's falls had been related to doing things she would have been safer to have staff assistance with. RN-A said fall interventions included signs, toileting assistance and getting her up early. RN-A said the most recent fall occurred because someone had plugged R1's recliner in and said it may have been staff or family. RN-A said if family plugged in the chair that was not something staff would have looked for. RN-A said appropriate footwear would include grip socks or non-slip footwear. During interview on 1/13/25 at 4:23 p.m., family member (FM)-A stated when R1 fell the lift chair was operational and R1 raised herself up. FM-A said the chair was not supposed to be plugged in. FM-A said a family member may have plugged in the recliner when they visited but said none of R1's family members had visited FM-A the day she fell. FM-A said it was not the first or even the second time R1 had fallen from the recliner. FM-A said R1 had declined cognitively and physically and would not have been able to plug the	F0689		

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F0689 SS = G	Continued from page 7 chair in by herself. During interview on 1/13/25 at 4:47 p.m., NA-B said, the day R1 fell, she had been coming out of another room and had been alerted by a hospice nurse that R1 was on the floor. NA-B said when she last saw R1, she was in the recliner asleep but could not remember if her feet were up or not. NA-B said when she found R1 she was face down in front of the recliner and said there was a lot of blood. NA-B said she was aware the recliner was not supposed to be plugged in due to previous falls but said she never thought to check to see if it was plugged in because she assumed no one would have plugged it in. NA-B said she was sure both family and staff had plugged in R1's recliner chair. During interview on 1/14/26 at 10:26 a.m., RN-B stated R1 had had more than one fall from the recliner and said the care plan had been updated to include leaving the chair unplugged in November of 2024. RN-B said she was not sure how the chair was getting plugged in but said if staff saw R1 in the recliner with her feet up they should have checked to make sure it was not plugged in. During interview on 1/14/26 at 10:45 p.m., the interim director of nursing (DON) stated R1 had multiple falls from the recliner and said it was care planned that the chair was not supposed to be plugged in. The interim DON said staff should have been checking to ensure the chair was unplugged and said the recliner was only to be used as a stationary chair. Facility Policy Using the Care Plan dated 1/2026, indicated the care plan shall be used to develop the residents daily care routines and be available to staff who have responsibility for providing care. The Kardex will be comprised of interventions from the care plan. Health care personnel are responsible for following the residents care plan.	F0689		