Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 16, 2025

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

RE: CCN: 245396
Cycle Start Date: April 28, 2025

Dear Administrator:

On June 13, 2025, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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June 16, 2025

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

Re: Reinspection Results
Event ID: 4HMU12

Dear Administrator:

On June 13, 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 April 28, 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
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
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May 15, 2025

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

RE: CCN: 245396
Cycle Start Date: April 28, 2025

Dear Administrator:

On April 28, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 28, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 28, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	C 04/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/23/25 through 4/25/25, and 4/28/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53962522C (MN00111924). No deficiencies issued. As a result of the survey a deficiency was cited at F880. 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.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		6/9/25

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

Electronically Signed | 05/21/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 2 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement adequate use of personal protective equipment (PPE) and hand hygiene during direct care services for 1 of 1 resident (R3) who required enhanced barrier precautions (EBP) with an indwelling device and open wound with a dressing change. Findings include: R3's annual Minimum Data Set (MDS) dated 4/11/25, identified moderately impaired cognition. He required substantial/maximum assistance with toilet hygiene, shower/bathe, personal hygiene, sit to stand, toilet and chair/bed to chair transfers, dependent for lower body dressing, and used a manual wheelchair for mobility. He had a suprapubic (a device inserted a couple inches below the naval/belly button, directly into the bladder) urinary catheter and always continent of bowel. Diagnoses included benign prostatic	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: - R3 direct care services will be delivered following enhanced barrier precautions. - LPN-A, NA-A, and NA-B will be reeducated on appropriate use of PPE use during contacts with residents that require Universal Precautions as well as Enhanced Barrier Precautions (EBP) How the facility will identify other residents having the potential to be affected by the same deficient practice: - Facility will conduct an audit of resident medical records to assure those requiring the use of enhanced barrier precautions are appropriately identified, care planned and implemented.	

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F 880	Continued From page 3 hyperplasia (BPH) (enlargement of the prostate), neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems, osteoporosis (bone loss), dementia, Parkinson's (a nervous system disorder that worsens over time), and a stage three pressure ulcer (involve full thickness skin loss potentially extending into the subcutaneous tissue layer. R3's care plan dated 4/17/25, indicated care for a suprapubic catheter due to neurogenic bladder and chronic urinary retention and directed staff to monitor for any trouble with catheter leaking and signs and symptoms of a urinary tract infection (UTI) such as change in color or cloudy urine, burning, fever, chills and observe skin integrity at catheter site. He required assistance with activities of daily living (ADLs) and staff were directed to transfer him with a gait belt, walker, and assistance of two. Care plan did not include EBP. During a continuous observation on 4/24/25 from 1:42 p.m. to 2:03 p.m., -1:42 p.m. located outside of R3's room was EBP signage and a large container with pockets that hung on the outside of his door which contained PPE supplies. Signage identified everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident Care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use with central line, urinary catheter, feeding tube, and tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Nursing	F 880	What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: - Re-Education will be provided to facility staff regarding appropriate use of personal protective equipment, enhanced barrier precautions, hand hygiene and general infection control practices. The facility policy on Enhanced Barrier precautions will be reviewed. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: - The Director of Nursing and/or designee will conducts audits of the appropriate implementation of enhanced barrier precautions and hand hygiene practices. Audits will be completed three times per week for eight weeks. Audits will be reviewed by DON or designee to determine if further education is necessary. Results of audits will be reviewed a the next Quality Assurance Committee meeting.	

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F 880	Continued From page 4 assistant (NA)-A and NA-B entered R3's room without application of PPE (gown and gloves) and assisted R3 into his wheelchair. NA-A positioned herself in front of him, reached down and attempted to pull R3's pant leg down with her bare hands and stated, "his catheter bag was leaking". NA-A and NA-B placed gloves on. NA-B pulled up his left pant leg and identified the clamp to the urinary catheter tubing may have been broken and urine had leaked onto his pants leg, socks and left shoe. NA-A sat down on the floor in front of him and removed his left shoe and knee-high sock, carried it over to the sink while it dangled from her hand and rinsed it in the under running water. NA-B kneeled on the floor in front of him, placed papers towels on the floor underneath the catheter bag, disconnected the straps from his lower leg and tubing/catheter collection bag from R3, wiped off end of tubing with an alcohol swab, and connected the new tubing end to the resident's catheter tubing, then placed the old catheter collection bag and tubing into the garbage can. NA-A kneeled on the floor with left knee and positioned herself in front of him. Both NA-A and NA-B sat on the floor, threaded the leg straps through his leg bag and around his lower left leg. NA-B removed her gloves, washed her hands, and exited the room. NA-B re-entered the room, carried a pair of scissors without a gown on, placed gloves on, and sat on the floor in front of him, and cut the leg straps shorter. NA-A and NA-B removed their gloves, failed to sanitize or wash their hands, and applied clean gloves. NA-A and NA-B assisted him up to stand, pulled down his pants and brief, completed peri cares. NA-A stated the Mepilex dressing fell off his open wound on his buttock, needed to be changed, used walkie to radio licensed practical nurse (LPN)-A.	F 880		

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F 880	Continued From page 5 - At 1:57 p.m. LPN-A entered the room without a gown donned and was already wearing gloves. LPN-A failed to remove gloves, sanitize or wash hands and apply clean gloves before caring for R3. LPN-A placed a Mepilex dressing over a quarter sized open area located on the left inner buttock. LPN-A placed a new dressing around the suprapubic urinary catheter site located on his abdomen, removed gloves, washed her hands and exited the room. NA-A and NA-B removed his soiled pants, placed a clean pair on, and assisted him into his wheelchair, removed their gloves, and washed hands with soap and water. Observation ended at 2:03 p.m. During an interview on 4/24/25 at 2:04 p.m., NA-A stated R3 was currently on EBP due to suprapubic catheter, wound on his buttocks, and current UTI. She should have gowned up when she entered his room and forgot to. NA-A added, it would be important to have applied a gown to prevent the spread of infection and verified the staff in R3's room during care all did not have gowns on. During an interview on 4/24/25 at 2:15 p.m., NA-B stated R3 was in EBP due to his suprapubic urinary catheter. Staff were expected to wear PPE included a gown when they worked with his urinary catheter, during cares, wound, and changing his brief, for infection control protection. She should have placed a gown on before she entered the room but it slipped her mind. She had not expected to find his urinary catheter leaking on his pants, socks, and shoe. NA-B verified he had a current UTI and was being treated for it. During an interview on 4/24/25 at 4:30 p.m., LPN-A stated R3 had an open pressure wound	F 880		

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F 880	Continued From page 6 located on the upper left part of the right inside gluteal fold the size of a quarter. Due to how often he moved around the Mepilex dressing fell off. He was placed in EBP for his suprapubic catheter and had a current UTI. Staff would be expected to wear a gown and gloves (and goggles if expected to be splashed) to help the prevent spread of germs and infection. She forgot to wear a gown and should have protected her clothing while she changed his dressing over the suprapubic site and on his gluteal fold. During an interview on 4/28/25 at 4:56 p.m., director of nursing (DON) stated staff would be expected to follow the EBP sign the moment they realized they would be completing cares and/or toileting a resident to help prevent the spread of infection. It was not recommended for staff to have sat on the resident's floor due to infection control concerns. Facility Enhanced Barrier Precautions signage identified everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident Care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use with central line, urinary catheter, feeding tube, and tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Facility policy Enhanced Barrier Precautions dated 3/2025, identified the use of EBP within the facility was recommended by the Center of Disease Control (CDC) to reduce the	F 880		

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F 880	Continued From page 7 transmission of multidrug-resistance organisms (MDROs) through the use of gown and glove use during high contact resident care activities that provide opportunities of transfer of MDROs to staff hands and clothing and maybe transferred from resident-to-resident during these high-contact care activities. Definition of a MDRO was organisms that have become resistant to multiple types of drugs that are normally used to treat those organisms. Examples of high-contact resident care activities required gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: urinary catheter, wound care, stage 2 pressure ulcers, diabetic ulcers, venous stasis ulcers, arterial ulcers, open social wounds. Clear signage wound be expected to be posted on the door or wall outside the resident room indicating the type of precautions and required personal protective equipment (PPE) (e.g. gown and gloves).	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 4HMU11

Dear Administrator:

The above facility was surveyed on April 23, 2025, through April 28, 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:

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
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00633	A. BUILDING: _____ B. WING _____	C 04/28/2025

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/23/25 through 4/25/25 and 4/28/25, 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, and the following licensing order was issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was viewed: H53962522C (MN00111924). As a result of the survey a licensing orders was issued at 1385. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement adequate use of personal protective equipment (PPE) and hand hygiene during direct care services for 1 of 1 resident (R3) who required enhanced barrier precautions (EBP) with an indwelling device and open wound with a dressing change. Findings include: R3's annual Minimum Data Set (MDS) dated 4/11/25, identified moderately impaired cognition. He required substantial/maximum assistance with toilet hygiene, shower/bathe, personal hygiene, sit to stand, toilet and chair/bed to chair transfers,	21385	Corrected.	6/9/25

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21385	Continued From page 3 dependent for lower body dressing, and used a manual wheelchair for mobility. He had a suprapubic (a device inserted a couple inches below the naval/belly button, directly into the bladder) urinary catheter and always continent of bowel. Diagnoses included benign prostatic hyperplasia (BPH) (enlargement of the prostate), neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems, osteoporosis (bone loss), dementia, Parkinson's (a nervous system disorder that worsens over time), and a stage three pressure ulcer (involve full thickness skin loss potentially extending into the subcutaneous tissue layer. R3's care plan dated 4/17/25, indicated care for a suprapubic catheter due to neurogenic bladder and chronic urinary retention and directed staff to monitor for any trouble with catheter leaking and signs and symptoms of a urinary tract infection (UTI) such as change in color or cloudy urine, burning, fever, chills and observe skin integrity at catheter site. He required assistance with activities of daily living (ADLs) and staff were directed to transfer him with a gait belt, walker, and assistance of two. Care plan did not include EBP. During a continuous observation on 4/24/25 from 1:42 p.m. to 2:03 p.m., -1:42 p.m. located outside of R3's room was EBP signage and a large container with pockets that hung on the outside of his door which contained PPE supplies. Signage identified everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident Care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting	21385		

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21385	Continued From page 4 with toileting, device care or use with central line, urinary catheter, feeding tube, and tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Nursing assistant (NA)-A and NA-B entered R3's room without application of PPE (gown and gloves) and assisted R3 into his wheelchair. NA-A positioned herself in front of him, reached down and attempted to pull R3's pant leg down with her bare hands and stated, "his catheter bag was leaking". NA-A and NA-B placed gloves on. NA-B pulled up his left pant leg and identified the clamp to the urinary catheter tubing may have been broken and urine had leaked onto his pants leg, socks and left shoe. NA-A sat down on the floor in front of him and removed his left shoe and knee-high sock, carried it over to the sink while it dangled from her hand and rinsed it in the under running water. NA-B kneeled on the floor in front of him, placed papers towels on the floor underneath the catheter bag, disconnected the straps from his lower leg and tubing/catheter collection bag from R3, wiped off end of tubing with an alcohol swab, and connected the new tubing end to the resident's catheter tubing, then placed the old catheter collection bag and tubing into the garbage can. NA-A kneeled on the floor with left knee and positioned herself in front of him. Both NA-A and NA-B sat on the floor, threaded the leg straps through his leg bag and around his lower left leg. NA-B removed her gloves, washed her hands, and exited the room. NA-B re-entered the room, carried a pair of scissors without a gown on, placed gloves on, and sat on the floor in front of him, and cut the leg straps shorter. NA-A and NA-B removed their gloves, failed to sanitize or wash their hands, and applied clean gloves. NA-A and NA-B assisted him up to stand, pulled down his pants and brief,	21385		

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21385	Continued From page 5 completed peri cares. NA-A stated the Mepilex dressing fell off his open wound on his buttock, needed to be changed, used walkie to radio licensed practical nurse (LPN)-A. - At 1:57 p.m. LPN-A entered the room without a gown donned and was already wearing gloves. LPN-A failed to remove gloves, sanitize or wash hands and apply clean gloves before caring for R3. LPN-A placed a Mepilex dressing over a quarter sized open area located on the left inner buttock. LPN-A placed a new dressing around the suprapubic urinary catheter site located on his abdomen, removed gloves, washed her hands and exited the room. NA-A and NA-B removed his soiled pants, placed a clean pair on, and assisted him into his wheelchair, removed their gloves, and washed hands with soap and water. Observation ended at 2:03 p.m. During an interview on 4/24/25 at 2:04 p.m., NA-A stated R3 was currently on EBP due to suprapubic catheter, wound on his buttocks, and current UTI. She should have gowned up when she entered his room and forgot to. NA-A added, it would be important to have applied a gown to prevent the spread of infection and verified the staff in R3's room during care all did not have gowns on. During an interview on 4/24/25 at 2:15 p.m., NA-B stated R3 was in EBP due to his suprapubic urinary catheter. Staff were expected to wear PPE included a gown when they worked with his urinary catheter, during cares, wound, and changing his brief, for infection control protection. She should have placed a gown on before she entered the room but it slipped her mind. She had not expected to find his urinary catheter leaking on his pants, socks, and shoe. NA-B verified he had a current UTI and was being treated for it.	21385		

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21385	Continued From page 6 During an interview on 4/24/25 at 4:30 p.m., LPN-A stated R3 had an open pressure wound located on the upper left part of the right inside gluteal fold the size of a quarter. Due to how often he moved around the Mepilex dressing fell off. He was placed in EBP for his suprapubic catheter and had a current UTI. Staff would be expected to wear a gown and gloves (and goggles if expected to be splashed) to help the prevent spread of germs and infection. She forgot to wear a gown and should have protected her clothing while she changed his dressing over the suprapubic site and on his gluteal fold. During an interview on 4/28/25 at 4:56 p.m., director of nursing (DON) stated staff would be expected to follow the EBP sign the moment they realized they would be completing cares and/or toileting a resident to help prevent the spread of infection. It was not recommended for staff to have sat on the resident's floor due to infection control concerns. Facility Enhanced Barrier Precautions signage identified everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident Care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use with central line, urinary catheter, feeding tube, and tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Facility policy Enhanced Barrier Precautions dated 3/2025, identified the use of EBP within the	21385		

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21385	Continued From page 7 facility was recommended by the Center of Disease Control (CDC) to reduce the transmission of multidrug-resistance organisms (MDROs) through the use of gown and glove use during high contact resident care activities that provide opportunities of transfer of MDROs to staff hands and clothing and maybe transferred from resident-to-resident during these high-contact care activities. Definition of a MDRO was organisms that have become resistant to multiple types of drugs that are normally used to treat those organisms. Examples of high-contact resident care activities required gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: urinary catheter, wound care, stage 2 pressure ulcers, diabetic ulcers, venous stasis ulcers, arterial ulcers, open social wounds. Clear signage wound be expected to be posted on the door or wall outside the resident room indicating the type of precautions and required personal protective equipment (PPE) (e.g. gown and gloves). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring enhanced barrier precautions (EBP) were followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with personal protection equipment with identified EBP. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21385		