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 Therefore, the NATCEP prohibition is rescinded.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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2025

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

RE: CCN: 245396

Cycle Start Date: December 4, 2025

Dear Administrator:

On December 4, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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),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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 4, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 4, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 4, 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.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 4, 2026.. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

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.

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.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2025

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

Re: Event ID: 1DD152-H1

Dear Administrator:

The above facility survey was completed on December 4, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

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 **12/04/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 12/3/25 through 12/4/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey. H53969162C (2681202)	20000		12/29/2025

Office of Primary Care and Health Systems Management

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 **12/04/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 12/3/25 through 12/4/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53969162C (2681202) and a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE. However, as a result of the investigation, a deficiency was cited at F609. 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		12/29/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the	F0609	The facility will immediately ensure that any alleged violations involving affected resident(s) are reported, investigated, and documented in accordance with the existing reporting policy, with appropriate notifications made to required entities. Any gaps identified will be corrected promptly to protect resident's health and safety. The facility will provide re-education to employees on the existing policy and procedure for identifying, reporting, and documenting alleged violations. Education will emphasize staff responsibility and accountability for timely reporting as well as ensuring sufficient information is included describe the	01/12/2026

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

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 1 allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit a report with sufficient information to describe the alleged violation to the State Agency (SA) without omitting information or misleading information to make the incident appear less serious than it was for 1 of 1 residents (R1) reviewed. Findings include: R1's significant change Minimal Data Set (MDS) dated 9/14/25, indicated R1 had diagnoses which included Alzheimer's disease, vascular dementia with psychotic disturbance, age related osteoporosis. R1 had moderately impaired cognition. R1's care plan revised on 12/1/25, indicated R1 had a selfcare deficit related to impaired mobility, Alzheimer's disease, depression, and a change in condition related to unknown etiology. R1's care plan identified R1 was non-ambulatory and required assist of one staff utilizing an EZ (brand of mechanical lift) stand for transfers as of 8/29/25. R1's care plan was revised on 12/1/25, identified R1 now required an EZ lift (full body mechanical lift) with assist of two staff members for transfers as R1 was non-weight bearing to right lower extremity. R1's Fall-Staff Assisted Fall incident report dated 11/29/25 at 6:15 p.m., identified resident was assisted to the floor with staff present. Staff attempted to pivot transfer and resident's legs got weak and they helped lower her to the floor slowly. There were no injuries noted. Resident was care planned to be an	F0609	Continued from page 1 allegation. The facility will conduct audits of alleged violation reports and investigations to assure they have sufficient information to describe the allegation. Audits will be completed weekly for 4 weeks, then monthly for a minimum of 90 days. Audit results will be reported to and reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure sustained compliance	

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 2 assist of one utilizing an EZ stand. Statement from nursing assistant (NA)-A, stated NA-A attempted to pivot transfer resident and she was unable to complete the transfer and slowly fell to her knees. NA-A helped her into a sitting position and called for help. Facility report number 362429 to the SA dated 12/1/25, indicated on 11/29/25 at 6:15 p.m., Resident was lowered to the floor during a transfer. Resident was assessed at the time of the fall and no immediate injuries were noted. Swelling to the right ankle and foot appeared on 12/1/25, staff requested an order for imaging. Imagining results showing the following, obtained 12/1/25, “Slightly displaced fracture distal fibula metaphysis, oblique image not obtained limiting evaluation of the distal tibia lateral aspect, lateral talar dome also limited evaluation, osteopenic appearing bone, soft tissues swelling surrounding the ankle, and small ankle effusion.” Incident details included staff member involved with the fall was immediately suspended. Resident status was changed to non-weight bearing and transfer status adjusted to use of the Hoyer lift at this time. However, the facility report to the SA lacked evidence R1 was pivot transferred assist of one rather than with an EZ mechanical stand as R1 had required per plan of care. Review of email chain with director of nursing (DON) and SA revealed the following: -On 12/2/25 at 7:41 a.m., SA sent message to DON to answer the following questions: 1. What was the root cause of the fall? 2. What was [R1] care planned prior to the fall? -On 12/2/25 at 8:58 a.m., DON sent message to the SA stating the root cause of the fall was weakness and R1 was care planned for use of EZ-stand with one assist. The staff member has been suspended at this time during the investigation. DON failed to provide additional information regarding the root cause of the fall being R1 was pivot transferred with assist of one staff member when R1 required the use of a mechanical EZ stand assist of one to transfer. On 12/3/25 at 1:08 p.m., licensed practical nurse (LPN)-A stated she reported to registered nurse (RN)-A R1’s care plan was not followed which resulted in a fall on 11/29/25, at approximately 6:15 p.m. On 12/4/25 at 10:24 a.m., RN-A stated she received a	F0609		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 3 call from LPN-A on 11/29/25, at approximately 6:15 p.m., and LPN-a reported staff had pivot transferred R1 rather than utilizing an EZ stand as R1 required which resulted in a staff assisted fall. On 12/4/25 at 12:05 p.m., DON stated R1's fall was discussed at the interdisciplinary team (IDT) meeting on 12/1/25. DON stated it was reported R1's fall occurred and R1's care plan had not been followed at the time of the fall. DON confirmed she submitted the report to the SA after identification of R1's fracture, but DON was unsure why the report did not contain information related to how R1 was transferred at the time of the fall or that R1's care plan was not followed. Further, DON stated the SA reached out to her by email and had asked what R1's transfer status was prior to the fall to which DON answered the question and did not provide any further detail again regarding how R1 was transferred at the time of the fall and R1's care plan was not followed. On 12/4/25 at 2:15 p.m., during the exit conference with DON and administrator, administrator stated they had not investigated the incident yet or interviewed the resident or staff involved before making the report to the SA, so the facility had not confirmed the care plan was not followed, even though the incident report contained the information and was verbally communicated by RN-A.	F0609		
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 ensure the care plan was followed during staff assisted transfer for 1 of 3 residents (R1), who fell while being transferred. This resulted in actual harm when R1 sustained a fracture. Due to actions taken by the facility, following the fall, this	F0689	"Past Noncompliance - no plan of correction required"	12/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 4 is being issued at past non-compliance. Findings include: R1's significant change Minimum Data Set (MDS) dated 9/14/25, indicated R1 had diagnoses which included Alzheimer's disease, vascular dementia with psychotic disturbance, age related osteoporosis, and R1 had moderately impaired cognition. R1's care plan revised on 12/1/25, indicated R1 had a self care deficit related to impaired mobility, Alzheimer's disease, depression, and a change in condition related to unknown etiology. R1's care plan identified R1 was non-ambulatory and required assist of one staff utilizing an EZ (brand of mechanical lift) stand for transfers as of 8/29/25. R1's care plan was revised on 12/1/25, identified R1 now required an EZ lift (full body mechanical lift) with assist of two staff members for transfers as R1 was non-weight bearing to right lower extremity. R1's Fall-Staff Assisted Fall incident report dated 11/29/25 at 6:15 p.m., identified resident was assisted to the floor with staff present. Staff attempted to pivot transfer and resident's legs got weak and they helped lower her to the floor slowly. There were no injuries noted. Resident was care planned to be an assist of one utilizing an EZ stand. Statement from nursing assistant (NA)-A, stated NA-A attempted to pivot transfer resident and she was unable to complete the transfer and slowly fell to her knees. NA-A helped her into a sitting position and called for help. R1's progress notes revealed the following: -On 11/29/25, communication to the physician included resident had a staff assisted fall/lowered to the ground this evening. Resident was an EZ stand, and staff tried to pivot, not looking at Kardex before transferring. Resident had no injuries noted. -On 11/29/25, at 6:15 p.m. resident was assisted to the floor with staff present. Staff attempted to pivot transfer and resident's legs got weak and they helped lower her to the floor slowly. No injuries were noted. Resident was care planned to be assist of one with an EZ stand. Resident denied pain. Immediate intervention implemented included printed off sheet of each resident's transfer status for staff to review. -On 11/30/25, fall follow up included resident was having some right foot pain, unknown if associated with fall. Resident has had this foot pain in the past and	F0689		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 5 it has resolved on its own after about a week. Resident does not want ice or heat on area. Resident was given scheduled Morphine. -On 11/30/25, fall follow up included resident had been baseline that shift with no complaints of pain at that time. -On 12/1/25, LPN (licensed practical nurse) alerted writer to concern with resident's right lower extremity stating her foot was swollen. LPN indicated resident was able to bear weight but had complained of pain during sock placement. Based upon LPN's report, writer reviewed resident's chart to verify next hospice visit which was noted to be scheduled on that date. Message sent to hospice related to concern for further injury and unsure how to proceed. -On 12/1/25, Resident was having increased pain to her right foot. Resident had swelling and faint bruising noted. Swelling was noted specifically around her ankle and along to the top right side of her foot. Resident initially denied pain while standing in the EZ stand but staff reported that when applying her shoes resident was yelling out in pain. Hospice was made aware at visit today and sent a message to provider to advise and possibly do an x-ray. -On 12/1/25, fall follow-up indicated there was a new fracture to resident's right foot. Resident reported pain with movement of right foot or placing socks on. Resident denied pain when resting in one place. Resident declined ice at that time. Resident was not transferred utilizing a Hoyer (full body mechanical lift) and non-weight bearing to right lower extremity. -On 12/1/25, Resident was diagnosed with a slightly displaced fracture distal fibula metaphysis seen on x-ray. Family did not want to pursue surgery but were receptive to an orthopedic consult to get recommendations on weight bearing and stabilization of the ankle, and pain management. R1's X-Ray Ankle results dated 12/1/25, indicated slightly displaced fracture of distal fibula metaphysis (break in the lower part of the fibula bone), osteopenic appearing bone (a condition where bone density is lower than normal) and soft tissue swelling surrounding the ankle, and small ankle effusion (extra fluid in the ankle joint often caused by injury). R1's Pain Level Summary identified R1 rated her pain a 0/10 on 11/29/25 and a 10/10 on 12/2/25.	F0689		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 6 On 12/3/25 at 11:06 a.m., family member (FM)-A stated he was notified of R1's fall by the facility staff shortly after the fall occurred. FM-A stated staff reported staff was transferring R1 thinking R1 could stand independently, however R1's medical record identified she required the use of a mechanical lift. FM-A stated R1 had reported pain since the incident and R1 was now a full body mechanical lift for transfers. On 12/3/25 at 11:30 a.m., R1 was observed in her room laying in her bed. R1 had her call light within reach, and her right foot appeared to be wrapped. R1 stated she fell out of her chair two weeks ago which resulted in her injury and rated her pain a 10/10. There was a sling size medium on R1's recliner, however R1 was not sure how staff get her out of bed but stated "they get it done." On 12/3/25 at 12:00 p.m., NA-A stated she has been casually working at the facility for the last year. She had worked at the facility approximately three times in the last year. NA-A stated she worked at the facility on 11/29/25, and had not worked at the facility prior to that since beginning of September 2025. NA-A stated on 11/29/25, at approximately 6:30 p.m., NA-A was assisting R1 back to her room following the evening meal and R1 was requesting assistance from her wheelchair to her recliner. NA-A stated R1 stood up independently from her wheelchair and was unable to turn and pivot to sit in her recliner and started to fall to her knees. NA-A stated she assisted R1 to the floor and then assisted R1 from her knees to sit on her bottom. NA-A stated she was not utilizing a gait belt to transfer R1, and NA-A stated staff were expected to utilize a gait belt with all transfers for residents who were not independent however NA-A stated, "I thought I would be able to do it with out one." Further, NA-A stated if she was not familiar with a resident, she would refer to the resident's Kardex and care plan but "since I worked there, I know all the residents". NA-A stated staff who didn't work full time were expected to review each resident's care plan at the start of the shift, however that "is not reasonable". However, since the incident NA-A stated she was immediately educated by the floor nurse to ensure, "I am referring to each resident's care plan prior to assisting them." NA-A was suspended pending investigation, and a message was sent through the all-staff notification center regarding following care plans for transfers. On 12/3/25 at 12:18 p.m., NA-B stated R1 appeared to be confused at times and was assist of one staff and EZ stand mechanical lift for transfers, however recently	F0689		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 7 changed to a full body lift because of the recent fall. NA-B stated she was working the evening of R1's fall. NA-B had been walking past R1's room when NA-A called to her to get the nurse. NA-B stated NA-A had asked "is she [R1] not a pivot?" which NA-B then said, "no she is an EZ stand". Further, NA-B stated she was a part-time employee, and staff were expected to review each resident's Kardex to see their care levels. NA-B stated since the incident staff had to review each resident's care plan and transfers status and sign it. On 12/3/25 at 12:56 p.m., NA-C and NA-E accompanied by NA-D who was training, knock and enter R1's room. NA-C and NA-E each are carrying an electronic tablet device with them. R1 was sitting in her wheelchair and wanted to be transferred to her bed. NA-C grabbed the full body mechanical. NA-C and NA-E hooked the sling to the lift, then transferred R1 into her bed. R1 did not express pain or appear to be in pain during the transfer. On 12/3/25 at 1:08 p.m., licensed practical nurse (LPN)-A stated R1 had a diagnosis of dementia and memory was impaired. LPN-A stated for the past couple months R1 had required assist of one staff and EZ stand for transfers. LPN-A stated R1 would be considered a fall risk if staff were to transfer her outside of her careplan. LPN-A stated she was working on 11/29/25 at approximately 6:15 p.m. when staff reported R1 had fallen and was on the floor. LPN-A stated there was already another nurse in R1's room so LPN-A had offered to update R1's provider, hospice, family, and notify the on call registered nurse (RN)-A. LPN-A was directed by RN-A to write each resident's transfer status on paper and all staff had to review and sign it. Further, LPN-A stated there was an alert sent through the staff notification system on 12/1/25, reminding all staff to review the Kardex prior to transferring a resident. On 12/3/25 at 1:28 p.m., RN-B stated R1 previously required assist with a pivot transfer. R1's transfer status declined which resulted in R1 being switched to an assist of one EZ stand transfer a few months prior. RN-B stated on the evening of 11/29/25, approximately 6:15 p.m., RN-B was notified R1 was on the floor. RN-B entered R1's room to see R1 sitting on her bottom on the floor with NA-A behind her for support. RN-B stated NA-A reported she attempted to pivot transfer R1 and R1 got weak. NA-A lowered R1 to her knees and from there helped her into a seated position. RN-B assessed R1 for injury and there was no injury noted at the time, however RN-B confirmed she did not check R1's range of motion. Following the incident, RN-B was directed by RN-A to write down every resident's transfer status and	F0689		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 8 review with all staff currently working and oncoming shifts, as well as immediately educate NA-A. On 12/3/25 at 3:12 p.m., NA-F stated care plan revisions were communicated verbally through shift report however, staff were expected to review each resident's Kardex prior to assisting the resident due to frequent changes. NA-F stated staff were also expected to carry a tablet with them for accessibility to those Kardex's. On 12/3/25 at 3:21 p.m., NA-G stated R1 required assist of one and an EZ stand to transfer, however R1 had a recent fall due to a staff member not reviewing her careplan and R1 was now requiring the use of a full body lift to transfer. NA-G stated R1 had complained of pain to her ankle and utilized ice and heat packs to alleviate the pain. Further, NA-G stated since the incident staff had to review every resident's transfer status and sign that staff reviewed them all and all staff were reminded to review each resident's Kardex prior to transferring the resident to ensure no changes were made. NA-G stated staff were also expected to always carry the tablet with them to be able to access each resident's Kardex. On 12/4/25 at 10:24 a.m., RN-A stated she received a phone call from LPN-A on 11/29/25, at approximately 6:15 p.m. shortly after R1's fall had occurred. RN-A stated LPN-A had reported R1 had a staff assisted fall due to NA pivot transferring R1, no pain or injuries noted. RN-A directed staff to educate NA immediately on following the care plans and checking the Kardex as well as educating other staff currently working and oncoming shifts to carry a tablet and refer to the resident's Kardex before assisting the resident. On 12/4/25 at 10:36 a.m., RN-C stated in September R1 had a change in condition and transitioned to an EZ stand assist of one for all transfers due to weakness and cognition. RN-C stated she was made aware on the morning of 12/1/25, R1's ankle was swollen. R1 obtained x-rays and then RN-C was notified R1 had a fracture. Since the incident, RN-C stated there has been several things sent out by communication board and text messages to all staff about checking resident's Kardex prior to assisting a resident. On 12/4/25 at 11:31 a.m., NA-A stated each staff had access to a tablet to reference the resident's care plans, however NA-A was unsure what the facility policy or protocol was regarding the tablets. NA-A stated she did not have a tablet on 11/29/25, the day of R1's incident.	F0689		

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 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 9 On 12/4/25 at 12:05 p.m., interim director of nursing (DON) stated staff had reported R1's fall had occurred, and care plan had not been followed. Following the incident, DON stated the staff involved was immediately educated to review each resident's Kardex prior to assisting, all current staff working received reminder to review the Kardex as well as oncoming shifts. DON stated the NA involved was suspended and has not returned to the facility and management was working on plan for the NA moving forward. DON stated she had sent a notification to all staff regarding utilizing the Kardex prior to providing cares, transfers and safety concerns. DON also stated audits on transfers have started to ensure correct transfer according to care plan, ensuring staff were aware of where to locate information, and tablets were accessible to staff. Review of facility policy titled Transferring/Ambulating a Resident dated 11/23, identified the purpose of the policy was to provide guidance on safely transferring a resident from one surface to another. A transfer belt (gait belt) should be used when assisting a resident who required physical assistance with a transfer unless another piece of equipment such as a standing lift or full mechanical lift was used. The resident's level of assistance was captured with the resident's plan of care. Further, the policy directed staff to verify the resident's transfer status within their plan of care (i.e. Kardex) and place the transfer belt snuggly around the resident's waist.	F0689		