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	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Melrose	101 5th Avenue NW Melrose, MN 56352

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 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 [DATE], 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 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., (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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. - 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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).