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	07/29/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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	07/29/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1's skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. The document lacked evidence of the provider notification. R1's skin assessment dated [DATE] at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1's treatment administration record (TAR) dated 6/20/25 through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to document an assessment of the pressure ulcer, measurements, or description from 6/20/25 through 7/14/25, during the time period the facility nursing staff was responsible for R1's skin integrity. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress. LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified the treatment team, the dietitian, and the provider. On 7/28/25 at 1:16 p.m., LPN-D stated she would update the provider, the nurse manager, and the family about a new skin impairment. LPN-D stated she was just monitoring R1's open skin area progress but she did not document its status during her skin assessment on 6/30/25 since it was not a new skin impairment. LPN-D stated usually the RNs will do an evaluation for stuff like that. She just made sure the Mepilex dressing was in place. 7/28/25 at 1:21 p.m., RN-B stated she did not document a description and measurement about the new skin impairment on 6/20/25, and did not notify the nurse manager or the provider. RN-B stated she initiated the task to monitor the open skin area at R1's coccyx and could not find any documentation about when it was resolved. On 7/28/25 at 3:12 p.m., a care coordinator, registered nurse (RN)-C stated she expected licensed nurses to describe and measure any new skin impairment, documented in the progress note, initiate a task for monitoring process, and notified the care coordinator and the provider. RN-C stated nursing staff did not notify the provider about R1's new skin impairment and could not find any documentation about when R1's resolved skin impairment prior to her hospitalization. RN-C stated R1 was back from hospital today and she sustained pressure ulcer at her coccyx area with 9.0 cm length, 8.2 cm width, and 0.7 cm depth with tunneling. On 7/29/25 at 11:38 a.m., RN-D from R1's medical team office stated she could not find any new skin impairment notification in their system about R1 from 6/20/25 through 7/14/25. RN-D stated she received the only notification about R1's wound status today on 7/29/25 and they ordered a wound care consult. On 7/29/25 at 12:34 p.m., the medical director (MD)-A stated he expected nursing staff to follow change in condition and wound care policies. MD-A stated nursing staff had to notify the provider about a new skin impairment depending on the resident diagnosis. On 7/29/25 at 3:34 p.m., the director of nursing (DON) stated she expected nursing staff to follow a change in condition policy about a new skin impairment finding. the DON stated she expected staff to report any resident wound concerns to the provider immediately. The DON stated with new skin impairment, nurses had to update the care team, record the measurement and the description of the wound, open a task to monitor its healing process, updated the dietary department, the care plan, the provider, and the family. The DON stated nursing staff did not update the nurse manager about R1's new skin impairment. The facility policy for Change in Condition dated 7/2025 directed nurses to make detailed observations and gather relevant and pertinent information for the provider of a change in the resident's condition. The policy

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	07/29/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	07/29/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide care consistent with professional standard of practice to prevent worsening of pressure ulcer identified on 6/20/25 for 1 of 3 residents (R1) reviewed when the facility failed to provide appropriate assessment and treatment. This resulted in actual harm to R1 when she was identified with stage 3 pressure ulcer at coccyx area during admission at the hospital on 7/15/25. Findings include: According to the State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, revision 229, issued 4/25/25 a pressure ulcer and stage 3 pressure ulcer is defined as Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. On 7/29/25 at 10:09 a.m., during R1's wound dressing observation, RN-G stated R1's pressure ulcer measurements indicated the following: length: 5.5 cm; width: 3.5 cm; and depth: 1 cm. RN-G stated he noted an excoriation around the wound, blanchable, little slough, borderline stage 3 pressure ulcer. R1's admission Record dated 3/27/24 indicated R1's diagnoses included intervertebral disc degeneration, chronic respiratory failure with hypoxia, history of diseases of the skin and subcutaneous tissue, sepsis due to Escherichia coli, and post-traumatic stress disorder. R1's care plan dated 3/27/24, indicated R1 had intact cognition and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive assistance with activities of daily living (ADL) R1's skin evaluation document dated 6/20/25 at 8:24 p.m. indicated R1 had new skin impairment with an open skin area at her coccyx. The document also indicated Mepilex border (a wound dressing) applied, monitoring task initiated. R1's care plan review lacked evidence of the focus, goal and interventions reviewed after the new skin impairment finding on 6/20/25. Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to document an assessment of the pressure ulcer, measurements, or description from 6/20/25 through 7/14/25, during the time the facility nursing staff was responsible for R1's skin integrity. R1's treatment administration record (TAR) dated 6/20/25, through 7/14/25, indicated R1 refused wound care on 7/1, 7/6, 7/7, 7/8, 7/9, and 7/10. Record review lacked indication of a notification to R1's physician or the nurse manager about R1's refusal of wound care. R1's skin assessment dated [DATE] at 7:35 p.m. indicated R1 had an open skin area at her coccyx with Mepilex dressing intact. The note indicated R1 refused to reposition often from the recliner. R1's skin assessment and progress notes 7/7/25 and 7/14/25, lacked documentation of R1's pressure ulcer of the coccyx area. On 7/15/25 at 6:33 p.m., a progress note indicated R1 was very drowsy/lethargic all shift with blood pressure of 62/42 and nursing staff sent R1 to the hospital for further evaluation per provider order. On 7/15/25, an emergency department (ED) provider note indicated emergency medical services (EMS) brought R1 to the hospital for evaluation of low blood pressures, increased fatigue, increased weakness, and some disorientation. The note also indicated a discrepancy in the history from the nursing home staff and there was very minimal documentation in the chart. R1's MDS dated [DATE] indicated no unhealed pressure ulcer/pressure injury identified. On 7/24/25 at 1:15 p.m., a licensed practical nurse (LPN)-A stated if you noted a new skin impairment, nursing staff should provide assessment, description, measurement, document in the progress note, and notified the nurse manager, the provider, and the family, and initiated a task to monitor its progress. LPN-A stated with a pressure ulcer or injury she would keep the pressure off, notified