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	12/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 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 [DATE], 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 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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 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 is being issued at past non-compliance.Findings include:R1's significant change Minimum Data Set (MDS) dated [DATE], 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 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.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