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	01/14/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to implement care planned interventions to reduce the risk for burns for 1 of 4 residents reviewed (R4) who spilled hot coffee on herself.R4's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included parkinsonism, depression, anxiety and dementia. R4's care plan dated 12/11/25 identified intact cognition and indicated she was able to eat independently. The care plan identified a risk for altered nutritional status and directed staff to provide covered mugs for hot liquids outside the dining room. R4's Hot Liquid Safety Evaluation dated 9/19/25, indicated temperature of liquid not to exceed 180 degrees. The evaluation indicated R4 had an isolated event on 9/16/2025, follow up completed on 9/17/2025. Standard temperature of hot liquid supplied by facility was less than 180 degrees. No additional interventions indicated at this time, see progress note on 9/17/25. R4's Progress Notes indicated the following: 9/17/25, Discussed with R4 the coffee spill from the previous day. R4 indicated she was watching television and when she set her cup down, she was not looking and it fell onto her lap. R4 said she would be more careful and said the coffee was luke warm at best. Isolated event. 12/10/25, A pink/red area on left inner thigh measured 10 centimeters CM) x 6 cm and pink/red area on right inner thigh 13 cm x 3 cm. Areas are warm to touch and R4 reported they were tender. Cause indicated R4 spilled coffee in her lap. Staff to put covers on hot liquids when she took them outside the dining room. 12/11/25, Interdisciplinary team review, upon investigation, R4 was attending an activity where a movie was being watched. Coffee was served per preference. R4 was in control of the mug at the time she accidently spilled into her lap. Skin was immediately assessed. Care plan was updated to reflect the use of covered mugs when resident is consuming hot beverages outside of the dining room. During observation on 1/14/26 at 9:02 a.m., R4 was seated in a wheelchair in her room working on a puzzle. R4 had a coffee cup in front of her with no lid. R4 sated she just got the coffee and said it was nice and hot. R4 said the only reason she had spilled her coffee in the past was because she hit it with her elbow. She said ever since she was supposed to have a lid but said staff had not given her one. During interview on 1/14/25 at 9:08 am., NA-C said R4 liked to have coffee in her room and said she believed R4 was supposed to have a cover on the mug. During interview on 1/14/26 at 10:26 a.m., RN-B stated R4 had an isolated incident when she spilled in her room because she was not paying attention. RN-B said when R4 was not in the dining room she was supposed to have covered cups. During interview on 1/14/26 at 10:45 a.m., the interim director of nursing stated R4 should have a cover on her cup as directed in the care plan. Facility Policy Using the Care Plan dated 1/2026, indicated the care plan shall be used to develop the residents daily care routines and be available to staff who have responsibility for providing care. The Kardex will be comprised of interventions from the care plan. Health care personnel are responsible for following the residents care plan.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to protect 1 of 4 residents (R1) from avoidable accidents when care plan interventions were not implemented. This resulted in actual harm to R1 who fell out of a recliner and sustained a large hematoma (a solid swelling of clotted blood) and laceration to the front of her head.Findings include: R1's admission Record indicated she admitted to the facility 8/26/24. R1's diagnosis included dementia, depression, overactive bladder and osteoporosis. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she required substantial to maximal assistance for transfers and toileting. R1's care plan revised 12/19/25, identified a potential for injury related to a history of falls. Interventions included: signage in room, appropriate footwear and grip strips in room. The care plan identified a potential for injury related to a history of electric recliner use. The care plan indicated R1 sustained a fall from a lift recliner when operating the remote control independently on 12/16/25. The cord for the recliner was removed from the room. The care plan indicated the following interventions: 11/19/24, electric lift recliner: stationary only. Per therapy recommendation keep recliner unplugged to promote resident safety. The care plan indicated R1 was non-ambulatory and required the use of a mechanical stand device for transfers. R1's Kardex (care guide) dated 12/1/25, indicated, per therapy staff, keep recliner unplugged to promote resident safety. R1's incident reports and correlating Post-Fall Investigations identified the following: R1 incident report dated 5/29/25, indicated she was found face down on her wheelchair leg, on the floor in front of her recliner. The recliner was in the highest position, and it appeared R1 was attempting to self-transfer. Post-Fall Investigation dated 5/29/25, indicated Prior to fall, R1 was last observed resting in her recliner. R1 appeared to have attempted to self-transfer as recliner was in the highest position. Immediate intervention was to unplug the recliner for the night. New intervention indicated recliner to remain unplugged, however, R1's care plan dated 11/19/24, indicated recliner was not to be plugged in. R1's incident report dated 12/16/25, indicated staff were alerted R1 was on the floor face first, with pooling blood on the ground. R1 had her hands on her head trying to cover her forehead which filled her hands with blood. R1 had been last observed in her recliner and recliner was in the highest position at the time of the fall. R1 had a large hematoma on her forehead along with a skin tear. R1 also complained of pain to her right elbow. R1 was transferred to the emergency department (ED). Post Fall Investigation dated 12/16/25, indicated R1 had been resting in her recliner after lunch. R1 fell and hit her face on the ground after attempting to self-transfer from the recliner. R1's care plan reflected recliner to remain unplugged, care plan had not been followed. R1's ED Provider Note indicated R1 presented to the ED after she tried to get out of her lift chair in the nursing home and mis-stepped and fell forward onto her head. It sounded like she was non-ambulatory at baseline, but someone had her lift chair plugged in and so she tried to lift this up and tried to walk which was when she fell. She had no dizziness or lightheadedness that preceded the event, so it was a mechanical fall. R1 reported some left hip pain as well as right elbow pain and some mild neck pain. She reported a headache as well, especially overlying the large hematoma on the frontal region. R1's Progress Notes indicated the following: 12/16/25, Staff immediately paged an ambulance. Writer entered the room to see three staff present and nurse assessing resident for injuries. Writer noted recliner in high position and asked if it had been moved when staff responded to the fall. They stated no. Verified sticky notes in place on both sides of the cord indicating not to be plugged in per therapy. 12/16/25, Resident returned from ED at 6:30 p.m. R1 was transferred into bed as she was sleepy due to administration of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hydromorphone in the ED. Cares completed along with skin check. No changes to skin besides the hematoma to right elbow and right forehead. Swelling was reduced from when she left to the ED and bruising is noted. Skin tear was scabbed and no longer bleeding. 12/17/25, Bruising to right eye forming, swelling and hematoma. 12/17/25, Noted that care plan had not been followed in relation to recliner to remain unplugged. Labels remain in place to cord and battery that indicated for the chair to not be plugged in. During observation and interview on 1/9/26 at 9:37 a.m., R1 was seated in a wheelchair in her room. R1 had a fading bruise on her forehead. R1 said, I'm not good. I don't like being in this chair with the table in front of it. R1 said someone told her there was something wrong with her recliner so she could not sit in it. R1 stated she remembered falling from the recliner chair and said she was trying to go to bed. R1 said she usually asked for help but did not know if she had that day, then said she probably had not. R1 stated she got hurt and had a bruise on her head. A sign on R1's recliner said, resident do not sit. At 11:20 a.m., R1 remained seated in her wheelchair and appeared to be asleep. R1 had one foot on a foot pedal and the other foot was on the floor. R1 had regular socks on her feet, no anti slip footwear. During interview on 1/9/25 at 11:47 a.m., NA-A stated the staff carried iPads with the Kardex for each resident on it. The Kardex was viewed with NA-A and indicated stationary chair, wheelchair stored in bathroom. The Kardex did not identify appropriate footwear. During interview on 1/9/26 at 12:01 p.m., registered nurse (RN)-A confirmed R1 was wearing nylon stockings that were not anti-slip. RN-A said R1 had some cognitive impairment and said most of R1's falls had been related to doing things she would have been safer to have staff assistance with. RN-A said fall interventions included signs, toileting assistance and getting her up early. RN-A said the most recent fall occurred because someone had plugged R1's recliner in and said it may have been staff or family. RN-A said if family plugged in the chair that was not something staff would have looked for. RN-A said appropriate footwear would include grip socks or non-slip footwear. During interview on 1/13/25 at 4:23 p.m., family member (FM)-A stated when R1 fell the lift chair was operational and R1 raised herself up. FM-A said the chair was not supposed to be plugged in. FM-A said a family member may have plugged in the recliner when they visited but said none of R1's family members had visited FM-A the day she fell. FM-A said it was not the first or even the second time R1 had fallen from the recliner. FM-A said R1 had declined cognitively and physically and would not have been able to plug the chair in by herself. During interview on 1/13/25 at 4:47 p.m., NA-B said, the day R1 fell, she had been coming out of another room and had been alerted by a hospice nurse that R1 was on the floor. NA-B said when she last saw R1, she was in the recliner asleep but could not remember if her feet were up or not. NA-B said when she found R1 she was face down in front of the recliner and said there was a lot of blood. NA-B said she was aware the recliner was not supposed to be plugged in due to previous falls but said she never thought to check to see if it was plugged in because she assumed no one would have plugged it in. NA-B said she was sure both family and staff had plugged in R1's recliner chair. During interview on 1/14/26 at 10:26 a.m., RN-B stated R1 had had more than one fall from the recliner and said the care plan had been updated to include leaving the chair unplugged in November of 2024. RN-B said she was not sure how the chair was getting plugged in but said if staff saw R1 in the recliner with her feet up they should have checked to make sure it was not plugged in. During interview on 1/14/26 at 10:45 p.m., the interim director of nursing (DON) stated R1 had multiple falls from the recliner and said it was care planned that the chair was not supposed to be plugged in. The interim DON said staff should have been checking to ensure the chair was unplugged and said the recliner was only to be used as a stationary chair. Facility Policy Using the Care Plan dated 1/2026, indicated the care plan shall be used to develop the residents daily (continued on next page)

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