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	05/14/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to protect 2 of 2 residents (R2 and R1) from abuse. Staff used a personal cell phone to take a picture of R2's soiled brief, buttocks, and large bowel movement and the picture was sent to several other facility staff. This resulted in actual harm to R2 as she verbalized not trusting facility staff and was fearful to have a bowel movement. R1 was abused when staff used their personal cell phone to record R1's voice as she was repeatedly stating, help me, help me. The video was sent to several facility staff phones with the caption, I want to kill myself. The facility implemented corrective action, and the deficient practice was corrected on 5/08/26, prior to the survey, and was issued at past non-compliance.ˆ Findings include: ˆR2 R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had hemiplegia (muscular weakness) or hemiparesis (involving severe or total paralysis), anxiety disorder and depression. R2's MDS further indicated C2 was cognitively intact and usually understood by others.ˆ ˆThe MDS indicated she was dependent on staff for toileting and was always incontinent with bowel and bladder.ˆˆ R2's care plan (CP) dated 7/10/25, indicated R2 had alteration in elimination related to impaired mobility and incontinence of bowel and bladder, was cognitively intact and independent in decision making. R2 was difficult to understand at times, may become upset and had trouble rationalizing out a situation.ˆ ˆIn addition, R2 was identified as having trauma related to her adoptive family, R2 did not want to talk about it.ˆ A Facility Reported Incident (FRI), dated 5/08/26, indicated nursing assistant (NA)-A notified the DON she received a snapchat from NA-F but had not yet opened it yet.ˆ NA-A opened the snapchat to the DON on her phone with the administrator present. The message indicated it was sent by NA-F. The message included a picture of a resident's brief open, uncovered buttocks partially in the picture, and a bowel movement in the brief. Resident was not identified at that time. Immediate VA action plan implemented. HIPPA violation and exploitation of resident image occurred per report was indicated that occurred on 5/08/26 at 1:45 p.m.ˆ ˆThe Investigative Report Summary dated 5/13/26, indicated the social services designee (SSD) informed R2 that an image had been taken of her brief with a bowel movement (BM).ˆ The report indicated R2 was unaware this occurred while cares were occurring on 5/07/26 and did not appear distressed and had no concerns. Family member (FM)-A was informed of the incident and had no further concerns.ˆ The report also indicated a written statement was received by NA-C that stated she received a picture of R2 who was naked lying in bed with a brief covered in bowel on snapchat.ˆ I left the group chat and spoke with another coworker, NA-A, who also seen the picture and we both agreed to report it.ˆ Written statement from NA-I stated she was aware that a picture was sent, and it made someone uncomfortable.ˆ She stated she doesn't remember when the picture was taken, but she was in the room cleaning with the resident and the alleged perpetrator (AP) when it was taken.ˆ Written statement from NA-F stated she was pulled into the room to look at a big BM and was in a group chat and a picture was sent to the chat but did not see it, I was clicking through the snap chats really quick.ˆ The conclusion of the investigation indicated the incident was verified NA-F admitted in taking the photo 5/07/26 of R2's BM during brief changing, unaware of buttocks showing and was visible, and sending the image in a snapchat group (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	05/14/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	message.ˆ ˆThe report indicated all NA's involved were suspended and following the investigation re-education was provided on 5/08/26.ˆ During interview on 5/13/26 at 1:34 p.m., NA-A stated she reported the incident involving R2, NA-A stated she was called into the room and saw R2's buttock and a dirty brief laying on the bed with a large BM. [R2] was literally naked on the bed andˆ while I was walking out the door [NA-F] told me she sent me a picture to look at.ˆ NA-A stated that was when she went to DON's office to show her the picture.ˆ NA-A stated she did not think R2 knew the picture was taken but it was wrong. The morals and values at work are just wrong. During interview on 5/14/26 at 10:20 a.m., facilities regional nurse consultant (RNC) stated NA-F admitted in taking the picture of R2 and she was terminated due to company policy and procedures.ˆˆ During interview on 5/14/26 at 12:42 p.m., R2 stated she did not know what snapchat was and did not realize the content of the picture that was taken of her. After it was explained, R2 stated Oh, not really good, makes me feel nasty. R2 added, Oh yeah it's going to bother me, it's going to be hard to have a bowel movement.ˆ In addition, R2 stated, they should get fired, I hope so. During interview, R2 was tearful, her voice got quieter and her mood seemed more down as the conversation turned from introductions with writer to more specific information regarding the incident. During interview on 5/14/26 at 12:51 p.m., Family member (FM)-A stated the staff at the facility broke her [R2's] trust. Back in the day, before [R2's] stroke this situation would have embarrassed her and if she stated it would be hard to have a bowel movement, I believe it bothers her. R1 R1's quarterly (MDS) dated [DATE], indicated R1 had anxiety disorder, depression, non-traumatic brain dysfunction and Schizophrenia.ˆ The MDS further indicated that R1 was severely cognitively impaired, had verbal behavioral symptoms and required assistance with activities of daily living.ˆˆ R1's CP dated 2/11/26, indicated R1 was a vulnerable adult and calls out at night rather than use of call light and staff were to educate resident or responsible party regarding rights, encourage and praise positive behavior, if behavior patterns are concerned. The CP also indicated R1 was dependent on staff for meeting physical and social needs due to cognitive deficits, limited mobility and vision impairment. Staff were directed to respect resident's right to be alone at times.ˆ ˆR1's Kardex dated 5/11/26, indicated mood interventions for yelling out included: check with resident if any of these are the reasons she would be calling out-bathroom, pain, uncomfortable clothes, lonely, hungry or thirsty.ˆ A FRI dated 5/08/26, indicated staff brought to the attention of the Director of Nursing (DON) a video a staff member had taken and shared.ˆ The video showed a picture of a staff member. In the background, you could hear a resident [R1] stating help me, help me. The staff member identified in the video was nursing assistant (NA)-I.ˆ ˆ The Investigation Report Summary (IRS) dated 5/13/26, indicated NA-I was identified as taking the video, and NA-F sent the video to the DON on 5/08/26. NA-F added to the message, I just want to bring to your attention that I'm not the only one that has done this. [NA-I] has also sent stuff into snapchat.ˆ NA-F then emailed a video to the DON that was originally sent by NA-I to NA-F. This video was a recording of the camera pointed at NA-I's face that was partially visible, with a statement, I want to kill myself.ˆ In the background resident R1 could be identified as saying help repeatedly.ˆ No residents were shown in the video.ˆ DON made administrator aware of the report.ˆ Both NA-I and NA-F were already suspended pending another investigation.ˆ R1 was assessed for safety.ˆ The investigation indicated education was provided to all facility employees regarding Vulnerable adult's act, photos/recording and vulnerable adult reporting and all staff were expected to complete education prior to the start of their next shift on 5/08/26.ˆ During interview on 5/13/26 at 1:52 p.m., NA-C stated she received the video of R1 yelling and NA-I's caption on snap chat. NA-C stated she left the group as soon as she saw the video.ˆ NA-C stated the group chat started about two months ago and they were all friends outside of work. The group chat started out as funny videos at soft ball or selfies.ˆ The pictures never included residents or things like that until the video of R1. NA-C alerted the DON and Administrator when she received the video of R1. During interview on 5/14/26 at 10:12 p.m., regional nurse consultant (RNC) for the company stated she assisted with the investigations. NA-I admitted to taking the video of R1 and was terminated for her actions and for not following the (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	05/14/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	facility's policies.ˆ The Vulnerable Adult Policy effective 11/2025 indicated the organization values the dignity of each resident.ˆ It is our desire to provide care with the regard to the mission and values of the organization.ˆ The Policy further indicated under abuse any emotional or psychological abuse that includes but is not limited to humiliation, harassment, threats of punishment or derivation and unauthorized photographs and/or recordings of a resident, a resident's personal belongings and/or their personal space.ˆ The noncompliance started on 5/7/26, when staff took a picture, using their personal phone of a resident's buttocks then shared the picture via a social media platform with other staff at the facility. The noncompliance was corrected on 5/8/26, when the facility implemented training which included: What should I do if you see someone take a picture or video of a resident's incidents.ˆ Best rule of thumb don't even keep your phone on with you!