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	09/11/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the Ombudsman of transfers and discharges for 1 of 3 residents (R6) reviewed for hospitalizations. Findings include: R6's quarterly minimum data set (MDS) dated [DATE], indicated R6 was cognitively intact and had the following diagnoses: heart failure, hypertension, end stage renal failure and diabetes mellitus. R6's progress notes printed 9/11/25, indicated R6 was hospitalized from [DATE] to 5/5/25, with sepsis related pneumonia. Facility Ombudsman notification lacked evidence of R6's hospitalization in neither the April or May 2025 Ombudsman notifications. During interview on 09/10/2025 at 11:09 a.m., Director of Nursing (DON) stated the social worker was responsible for notifications to the Ombudsman for all hospitalizations, transfers and discharges. DON stated she was unsure of the social workers process as to when notifications were sent. DON then confirmed the Ombudsman notification list provided by facility did not include R6's hospitalization from 4/29/25 through 5/5/25. DON stated it was her expectation that all hospitalizations, discharges and transfers be reported to the Ombudsman. A policy related to Ombudsman notification was requested by not provided.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview the facility failed to ensure monthly pharmacy reviews were accurately completed and included review of hospital discharge orders for 1 of 3 residents (R6) reviewed for hospitalizations.Findings include:R6's quarterly minimum data set (MDS) dated [DATE], indicated R6 was cognitively intact and had the following diagnoses: heart failure, hypertension, end stage renal failure, diabetes mellitus, and irritable bowel syndrome with constipation.R6's progress note dated 4/29/25, indicated R6 was emergently transferred to the hospital and was subsequently admitted with sepsis. R6 returned to the facility on 5/5/25.R6's discharge transfer paperwork dated 5/5/25, indicated the following orders: Atorvastatin 40 mg-Wait to take this until May 6th morning; Linaclotide 145 mcg cap-wait to take this until May 6th morning.During interview on 09/09/2025 at 9:33 a.m., Consulting Pharmacist (CP) stated she was familiar with R6's hospitalization on 4/29/25 through 5/5/25. She stated she completed her monthly pharmacy review on May 21st which included discharge paperwork from 5/5/25. CP confirmed she did not see the orders for Atorvastatin and Linaclotide to begin on May 6th and hadn't written a recommendation related to those meds. She missed the order and should have written a recommendation for the medications to be restarted. Additionally, CP stated the potential was there for R6 to experience increased constipation or fecal impaction as a result.During interview on 9/10/25 at 11:09 a.m., Director of Nursing (DON) stated the pharmacy consultant reviewed all resident medications at least monthly for errors and irregularities. DON stated irregularities were addressed by the appropriate person, either the physician or nursing staff. DON confirmed the consultant pharmacist did not catch the transcription error for R6 and stated it looked like everyone missed it. DON stated the pharmacy review was an important component for resident safety.A policy titled Consultant Pharmacist Medication Regimen Review with a last review date of 3/2025 indicated the purpose was to the define the intent and process for drug regimen reviews of residents within long term care. The consultant pharmacist will review the medication regimen of each resident at least monthly and as needed. Irregularities will be reported to the Director of Nursing, the attending provider and a summary to the medical director for review and considerations of irregularities that may need to be further addressed with the attending provider. The facility will provide the consultant pharmacist with access to the resident's medical records, both electronic and paper records. Medication Regimen Review activities may include evaluating medication orders to determine the resident's orders represent optimal therapy; diagnosis or indication supports medication use; route of administration is appropriate; the prescribed dose is appropriate; the administration schedule is appropriate considering side effects and compatibility with other medications and diet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to maintain safe storage of medications on 1 of 3 medication carts when medication cart was left unlocked. Findings include:On 9/9/25 at 7:55 a.m., medication cart in common area of 100's unit was observed unlocked and unsupervised. Medication cart was placed outside of dining room, across from the unattended nurse's station.At 8:01 a.m., a staff person walked by cart to place something in the unattended nurses station. A second staff person walked past the unlocked medication cart. Neither attempt to lock the cart.At 8:04 a.m., a staff person with a laundry cart walked past the unlocked medication cart.At 8:05 a.m., registered nurse (RN)-C pushed a resident in a wheelchair past the unlocked medication cart.At 8:06 a.m., director of nursing (DON) walked past unlocked medication cart, but did not observe unlocked cart. RN-C walked past unlocked medication cart with supplies.At 8:07 a.m., housekeeping staff person walked past unlocked cart. RN-C walked past unlocked medication cart, noticed it was unlocked, and stopped to lock it prior to answering a phone.During interview on 9/9/25 at 8:09 a.m., RN-C confirmed she left the medication cart unlocked. RN-C was unsure when she left the cart unlocked. RN-C confirmed it was never acceptable to leave a medication cart unlocked.During interview on 9/10/25 at 10:54 a.m., DON stated she expected medication carts were locked any time someone turned away or left the cart. This would be important to prevent both staff and visitors from having access to medications. Facility policy titled Medication Guidelines - Long Term Care dated July 2025, included all compartments that contain medications should have been locked when not in use and should not be left unattended.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards of practice for 1of 24 residents (R1) reviewed for advanced directives documentation. This deficient practice gave staff access to inaccurate information. Findings include:R1's quarterly minimum data set (MDS) dated [DATE] indicated R1 admitted to the facility 3/13/25 and had the following diagnoses: hypertension, hyperlipidemia, arthritis, respiratory failure and depression.Review of R1's electronic medical record (EMR) on 9/7/25 indicated the code status as DNR, and current orders indicated DNR. However, the Advance Directive link in R1's EMR revealed an outdated advanced directive which indicated FULL CODE.A progress note titled Communication with Physician dated 7/28/25, indicated during hospitalization R1's code status was changed to Do Not Resuscitate, and the change was verified with R1's spouse. The note indicated social services would follow up and assist with updating healthcare directives.During interview on 9/7/25 at 3:08 p.m., registered nurse (RN)-C stated she would look to the EMR for a resident's code status, or the paper chart for the signed order from the physician. RN-C stated the paper chart and EMR should match. RN-C went on to say the advanced directive link in the EMR would be the best choice because it was linked to the signed official order. During interview on 9/7/25 at 3:10 p.m., trained medication aide (TMA)-A stated a resident's advanced directives were on the Kardex and on the Point of Care (POC) banner. TMA-A opened the EMR and clicked on the link to the resident Kardex. However, TMA-A did not access the Advance Directives link.During interview on 9/7/25 at 3:11 p.m., RN-B stated she could find the advanced directives in the resident's hard/paper chart or in the EMR on the banner. RN-B stated staff always verified they matched and compared the paper to the electronic chart to ensure they matched. RN-B did not access the Advance Directives link.During interview on 9/7/25 at 3:17 p.m., licensed practical nurse (LPN)A stated she would look to the resident's hard/paper chart to find advanced directives. LPN-A did not use the Advanced Directive link. During interview on 9/10/25 at 11;05 a.m., Director of Nursing (DON) stated it was the responsibility of the admitting or readmitting nurse to establish initial code status and obtain orders. DON stated staff could find code status in the EMR, the paper chart, and POC. DON located R1's code status on the EMR banner and stated it was listed as DNR. DON then confirmed R1's Advance Directives link was active and stated an outdated advance directive listed R1's code status as full code. DON stated her expectation was all locations listing code status matched. R1's did not match. DON stated it was important to have the correct code status in all locations to ensure the resident received the correct physician ordered care.A policy titled Code Blue/Cardiopulmonary Resuscitation-Skilled Nursing indicated the procedure to obtain advance directives through discussion with the resident and family and indicated how the wishes would be carried out in the event of cardiac arrest. The policy lacked a procedure to ensure all available locations of a resident's advance directives were matching.

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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** Based on observation, interview, and document review, the facility failed to properly disinfect shared equipment between use for 1 of 2 glucometers (medical device used to check blood sugar levels) reviewed for infection control. Findings include:R126's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment and diagnoses of diabetes mellitus (a disease where the body either does not produce enough insulin or not use insulin effectively) and dementia (memory loss).During observation and interview on 9/9/25 at 7:07 a.m., registered nurse (RN)-C completed a blood sugar check using a shared glucometer on R126 in R126's room. RN-C brought the shared glucometer back to the medication cart and used a Sani-Cloth germicidal disposable wipe on the glucometer for approximately 10 to 15 seconds. RN-C replaced the glucometer into the medication cart. RN-C confirmed she wiped the glucometer down for approximately 5 to 10 seconds and was dry soon after. RN-C checked the label and stated the contact time for the Sani-Cloth brand wipes was one minute .During interview on 9/10/25 at 10:54 a.m., the director of nursing (DON) stated she expected the glucometer to be disinfected between uses and following the policy.According to the [NAME] owner's manual, the device must be cleaned and disinfected after each patient with a CAVIPES disinfecting towelette by manufacturer Metrex and isopropanol as an active ingredient. Instructions included to allow the surface to remain wet for 2 minutes and allow to air dry.Facility policy for blood glucose sampling dated September 2025 included to follow the manufacturer's instructions for cleaning and disinfecting after each use.