Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee
Cura Of Melrose
125 5th Avenue Northwest
Melrose, MN 56352

RE: Project Number(s) SL30388015

Dear Licensee:

On August 5, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 24, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

June 6, 2024

Licensee
Cura of Melrose
125 5th Avenue Northwest
Melrose, MN 56352

RE: Project Number(s) SL30388015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

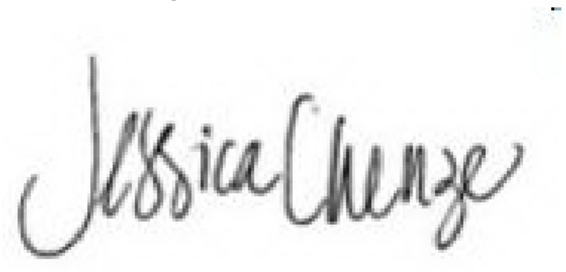
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30388	A. BUILDING: _____ B. WING _____	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	125 5TH AVENUE NW MELROSE, MN 56352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30388015-0 On May 21, 2024, through May 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 61 resident(s); 54 receiving services under the provider's Assisted Living license. An immediate correction order was identified on May 22, 2024, issued for SL30388015-0, tag identification 2310. On May 23, 2024, at 7:50 a.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of two employees (unlicensed personnel (ULP)-H) observed to provide medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 23, 2024, at 11:28 a.m., the surveyor observed unlicensed personnel (ULP)-H administer insulin to R9 in his apartment. With gloved hands, ULP-H wiped the resident's	0 510		

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0 510	Continued From page 2 abdomen, administered the prescribed dosage, returned to the kitchen to dispose of the needle, and documented the administration on the iPad. At this time, ULP-H removed her gloves and performed hand hygiene. After exiting the room, ULP-H stated she should have removed the gloves and done hand hygiene prior to documenting on the iPad. On May 24, 2024, at 7:50 a.m., clinical nurse supervisor (CNS)-A stated her expectation is staff remove gloves after performing administration of insulin and before documenting on the iPad. ULP-H's employee record contained a staff competency for hand washing procedure completed on April 17, 2024. The licensee's Hand Washing policy dated March 2024 noted hand hygiene should be completed after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 3 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name, telephone number, and email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 21, 2024, at 9:50 a.m., the surveyor toured the common areas of the facility with licensed assisted living director (LALD)-B. The surveyor observed a bulletin board inside the main entrance near the stairs, and a binder with documents including the grievance policy in the	0 550		

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0 550	Continued From page 4 mailbox area, which LALD-B stated was for resident and family use. The licensee's Complaint / Grievance - Assisted Living policy dated September 2022, noted the licensee would post, in a conspicuous place, information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual responsible for handling resident complain/grievances. On May 21, 2024, at 10:30 a.m., LALD-B stated the required content was in the form, but had been removed accidentally with the change of ownership. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 5 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01060		

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01060	Continued From page 6 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses included age related cognitive decline. R6's progress notes indicated: - May 4, 2024, R6 was transported to "Acute care ED [emergency department]" on May 3, 2024, due to elevated blood pressure and complaints of pain following an unwitnessed fall. - May 6, 2024, R6 did not return to the facility since the ED visit. - May 6, 2024, relocation form was sent to resident, resident's brother, and to the Office of Ombudsman for Long Term Care (OOLTC). - May 9, 2024, R6 was discharged from the hospital to skilled nursing facility. R6's Service Plan (Private) - Addendum to Contract, dated January 31, 2024, indicated R6 received services including assistance with bathing, dressing, meals, safety checks, monthly vitals, housekeeping and laundry. The service plan identified R6's brother as his emergency contact, and financial/health care power of attorney (POA). R6's Designated Representative Form, undated, indicated R6 had chosen his brother as his designated representative. R6's Notification of Emergency Relocation, dated May 6, 2024, indicated R6 was "Sent to Acute Care ED," on May 3, 2024, due to a fall with injury. The notification indicated "Family	01060		

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01060	Continued From page 7 notified" of the emergency relocation, the approximate date when the resident was expected to return to the facility was "unknown," included contact information for the OOLTC and Office of Ombudsman for Mental Health and Developmental Disabilities, and included information regarding the right to appeal if the facility refused to provide housing or services after the relocation. R6's record lacked evidence of a written notice provided to the resident that contained, at a minimum: - the name and contact information for the location to which the resident had been relocated and any new service provider. On May 24, 2024, at 8:15 a.m., clinical nurse supervisor (CNS)-A stated she wasn't aware that she needed to include the above contents on the relocation notice. The licensee's Emergency Relocation policy, dated September 2022, noted the licensee could remove a resident from the facility in an emergency if necessary, due to a resident's urgent medical needs. In the event of an emergency relocation, the policy directed the licensee would provide a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term care and Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 8 expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal, and will provide contact information for the agency to which the resident may submit an appeal. The policy also included the notice required will be delivered as soon as practicable to: - the resident, legal representative, and designated representative; - the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with the assisted living facility license for 17 of 24 employees (clinical nurse supervisor (CNS-A, registered nurse (RN)-C, regional registered nurse (RRN)-F), unlicensed personnel (ULP)-E, ULP-G, ULP-H, ULP-J, ULP-L, ULP-O, ULP-P, ULP-D, activity aide (AA)-S, AA-T, AA-U, ULP-V, ULP-W, maintenance (M)-X). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A began employment on October 29, 2023, to provide direct care services and supervision under the licensee's assisted living license. CNS-A obtained her RN license on June 16, 2006. Licensed assisted living director (LALD)-B provided a background study for CNS-A, submitted through a separate license operated by CNS-A's previous employer, dated January 7, 2004. RN-C	01290		

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01290	Continued From page 10 RN-C began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. RN-C obtained her RN license on August 9, 1994. LALD-B provided a background study for RN-C, submitted through a separate license operated by RN-C's previous employer, dated February 2, 2016. RRN-F RRN-F began employment on October 29, 2023, to provide support and supervision services under the licensee's assisted living license. RRN-F obtained her RN license on December 23, 2002. RRN-F provided a background study, which she stated she affiliated with the assisted living facility license after requested by the surveyors, dated May 23, 2024. ULP-E ULP-E began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-E, submitted through a separate license operated by ULP-E's previous employer, dated January 30, 2024. ULP-G ULP-G began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-G, submitted through a separate license operated by ULP-G's previous employer, dated June 18, 2015.	01290		

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01290	Continued From page 11 ULP-H ULP-H began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-H, submitted through a separate license operated by ULP-H's previous employer, dated April 30, 2014. ULP-J ULP-J began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-J, submitted through a separate license operated by ULP-J's previous employer, dated November 1, 2012. ULP-L ULP-L began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-L, submitted through a separate license operated by ULP-L's previous employer, dated February 2, 2016. ULP-O ULP-O began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-O, submitted through a separate license operated by ULP-O's previous employer, dated August 22, 2016.	01290		

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01290	Continued From page 12 ULP-P ULP-P began employment on October 29, 2023, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-P, submitted through a separate license operated by ULP-P's previous employer, dated May 7, 2024. ULP-D ULP-D began employment on February 6, 2024, to provide direct care services under the licensee's assisted living license. LALD-B provided a background study for ULP-D, submitted through a separate license operated by the same franchise, dated February 6, 2024. AA-S AA-S began employment on February 6, 2024, to provide activity services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:08 p.m., AA-S was determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated February 6, 2024. AA-T AA-T began employment on February 13, 2024, to provide activity services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:09 p.m., AA-T was determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated February 29, 2024.	01290		

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01290	Continued From page 13 AA-U AA-U began employment on February 13, 2024, to provide activity services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:10 p.m., AA-U was determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated February 13, 2024. ULP-V ULP-V began employment on March 4, 2024, to provide direct care services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:10 p.m., ULP-V was determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated February 29, 2024. ULP-W ULP-W began employment on March 11, 2024, to provide direct care services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:11 p.m., ULP-W was determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated April 9, 2024. M-X M-X began employment on April 1, 2024, to provide direct care services under the licensee's assisted living license. Upon review of the NETStudy 2.0 website, on May 23, 2024, at 12:12 p.m., M-X was	01290		

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01290	Continued From page 14 determined to be "eligible," however, was affiliated through a separate license operated by the same franchise, dated February 16, 2024. During telephone interview on May 23, 2024, at 12:35 p.m., owner (O)-Y stated he had been working with the Department of Human Services (DHS) and had been unable to affiliate employees with the current assisted living license, after the purchase of the facility in October, 2023, due to the long and complicated process. The facility's Employee File - Background Check policy, dated March 2023, indicated the licensee would conduct a Minnesota DHS Background Study on all employees and volunteers and contractors, and would keep copies of the completed background studies in the individual employee records; however, the policy did not indicate the background study must be affiliated with the assisted living license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790		

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01790	Continued From page 15 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790		

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01790	Continued From page 16 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 21, 2024, at 9:05 a.m., clinical nurse supervisor (CNS)-A stated the facility provided medication management services to the licensee's residents. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 2021, noted the registered nurse had	01790		

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01790	Continued From page 17 developed written procedures for the ULP, and noted the procedures must address a review by the registered nurse of the completion of this task to verify the task was completed accurately by the ULP. The licensee's Medication - Leave of Absence (LOA) Medication Set-up form, undated, lacked the following required content: - a review by the RN of the completion of the task to verify it was completed accurately by the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 18 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications, as required, for one of one resident (R5) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5's record lacked documentation of medication disposition upon R5's discharge from the facility. R5 was discharged to a long term care facility due to decline in functional ability on May 9, 2024, after receiving services for diagnoses including Alzheimer's Disease, depression, and chronic renal failure. R5's Discharge Care Plan, dated May 9, 2024, indicated R5 received services including cueing, assistance with bathing, dressing, grooming, hygiene, emergency evacuation, incontinence care, meals, safety checks, fall prevention, and medication management. The summary listed R5's medications, including the medication's name, strength, directions for administration and times to be administered, and indicated	01910		

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01910	Continued From page 19 "medications sent with family and will be given to NH [nursing home] nursing staff." R5's record lacked documentation of the disposition of the medications including the quantity of each medication, the prescription number as applicable, and names of staff and other individuals involved in the disposition, as required. On May 24, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-A stated they had not been including the above information when discharging residents and stated she had just learned from regional registered nurse (RRN)-F, after surveyors requested R5's discharge information, that the disposition of medications should include the quantity of each medication, the prescription number, and the names of staff and other individuals involved in the disposition. The licensee's Medication Disposal policy, dated August 2021, indicated, upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 20 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R3, R2) with a consumer bedrail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This practice resulted in an immediate order for correction on May 22, 2024. R3 R3's diagnoses included macular degeneration, osteoporosis, and obesity. R3's Service Plan dated April 1, 2024, noted services including escort, medication administration, safety checks, blood glucose monitoring, housekeeping, and laundry. R3's Notes, dated February 23, 2024, indicated,	02310		

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02310	Continued From page 21 "Bed rail per facility protocol placed on bed. [family member] was going to bring her old one home." R3's Assessment As of Date, dated February 23, 2024, indicated R3 had a standard bed frame and had a left sided bedrail in use, not secured to the bed (slides under the mattress) and was "in good condition, but the family will switch to a facility approved grab bar and purchase it for safety purposes." The assessment noted the bedrail was not appropriate at that time as it was not secured to the frame, and the family was willing to purchase a new device but declined additional safety checks to be put into place until the new bedrail arrived. R3's February 23, 2024, assessment lacked updated information about the new bedrail installed on the date of the assessment. R3's Clinical Update Assessment, dated March 6, 2024, indicated R3 had a standard bed frame and had a left sided bedrail in use, not secured to the bed (slides under the mattress) and was "in good condition, but the family will switch to a facility approved grab bar and purchase it for safety purposes." The assessment noted the bedrail was not appropriate at that time as it was not secured to the frame, and the family was willing to purchase a new device but declined additional safety checks to be put into place until the new bedrail arrived. R3's March 6, 2024, assessment lacked updated information about the new bedrail installed on February 23, 2024. On May 22, 2024, at 10:20 a.m., the surveyor observed R3's consumer bedrail with unlicensed personnel (ULP)-D. The bed was a queen-sized bed with the M-shaped assistive device on the left side of the bed. The device was white with a	02310		

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02310	Continued From page 22 black foam gripper covering and had a horizontal bar beneath the gripper with a mesh pocket attached, which included the name Avantis. ULP-D stated R3 utilized the device when getting in and out of bed. The surveyor observed the device was securely attached. R3's record lacked an assessment of the current Avantis assistive device, installed February 23, 2024, to include: -purpose and intention of the bed rail; -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -the resident's bed rail use/need assessment; -risk vs. benefits discussion (individualized to each resident's risks); -the resident's preferences; -installation and use according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; -any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -evidence the device had not been recalled. On May 22, 2024, at 10:58 a.m., registered nurse (RN)-C stated an assessment should have been completed for the newly installed device on February 23, 2024, and should have included the required information. RN-C stated she was not aware of the required content for bedrail assessments until recently and completed a new assessment today (during the survey) when realized the assessment did not include the required content. R2	02310		

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02310	Continued From page 23 R2's diagnoses included degenerative arthritis, cerebral vascular accident, and urge incontinence. R2's Service Plan dated July 10, 2023, noted services including daily health check, and daily vital sign monitoring. R2's Notes, dated January 31, 2024, indicated, the bedrail was applied to R2's bed and noted the bedrail was an Avantia M-safe contoured bedrail on the right side of the bed. R2's Clinical Update Assessment dated April 18, 2024, indicated R2 had a standard bed frame and had one bedrail in place that was purchased, Avantis M-safe contoured bedrail, in place on the right side of the bed, that was used for positioning while in bed and for getting in and out of bed. It noted education was provided and risks versus benefits were reviewed with R2. It noted R2 had a history of falling. R2's record lacked an assessment of the current Avantis assistive device, installed January 31, 2024, to include: -installation and use according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -evidence the device had not been recalled. On May 22, 2024, at 11:45 a.m., the surveyor observed R2's assistive device with RN-C. The bed was a twin-sized bed with the M-shaped assistive device on the right side of the bed. The device was white with a black foam gripper covering and had a horizontal bar beneath the gripper with a mesh pocket attached, which	02310		

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02310	Continued From page 24 included the name Avantis. The surveyor observed the device was securely attached. On May 22, 2024, at 10:58 a.m., RN-C stated the facility had determined as a whole, they would use the M-shaped device, and would ensure that it was installed correctly, and that they were checking for recalls. RN-C asserted that she had provided the surveyor with assessments titled Bed Safety for R3 and R2, however, those assessments were completed during the survey and were dated May 22, 2024. RN-C stated she was unaware of the requirement of the assessment to include the information that the devices were securely attached per manufacturer's directions and that they had checked for recall through the Consumer Product Safety Commission (CPSC). The facility's Side Rails policy, dated May 2024, indicated when an assisted living resident was utilizing bedrails (a medical device) on a bed, the facility would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of bedrails, and verify that the bedrail in use was of a safe design and utilized consistent with the manufacturer's directions. The policy noted the facility allowed one style of consumer bedrail within the facility. The RN must conduct an assessment to identify the purpose and intention of the bedrail, condition and description of the bedrail, use/need assessment, risk versus benefits discussion, installation and use according to manufacturer's guidelines, physical inspection of the bedrail, the intended purpose and risks regarding the bedrails, and whether the bedrail had the effect of being an improper restraint.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30388	A. BUILDING: _____ B. WING _____	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MELROSE	125 5TH AVENUE NW MELROSE, MN 56352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated documentation about a resident's bed rails includes, but is not limited to: -purpose and intention of the bed rail; -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -the resident's bed rail use/need assessment; -risk vs. benefits discussion (individualized to each resident's risks); -the resident's preferences; -installation and use according to manufacturer's guidelines; and -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. In addition, the FAQ indicated "licensees should refer to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as evidenced by supervisor review on May 23, 2024, however noncompliance remains at a scope and level of level three, widespread (I).	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/21/24*
Time: 11:40:47
Report: 7930241096

Food and Beverage Establishment Inspection Report

Location:

Centracare - Melrose Park View
125 5th Avenue Nw
Melrose, MN56352
Stearns County, 73

Establishment Info:

ID #: 0038343
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202561769
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET NEAR SERVING LINE
Violation Issued: No

Hot Water: = at 167.7 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED HAM--TWO DOOR UPRIGHT COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Type: Full
Date: *05/21/24*
Time: 11:40:47
Report: 7930241096
Centracare - Melrose Park View

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930241096 of 05/21/24.

Certified Food Protection Manager: Heidi M. Hollenkamp

Certification Number: 71452 Expires: 01/25/26

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us