



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

December 5, 2024

Licensee
Cure Home Health Inc
1509 East 22nd Street
Minneapolis, MN 55404

RE: Project Number(s) SL34362015

Dear Licensee:

Please Note: This notice amends the enforcement letter dated October 24, 2024. Specifically, correction order 0100 was amended to reflect accurate description of dwelling. Also, please note that an additional request for an informal conference has been included in this amended letter. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a survey on August 14, 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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 hearing must be in writing and received by the Department of Health within 15 business days of the 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

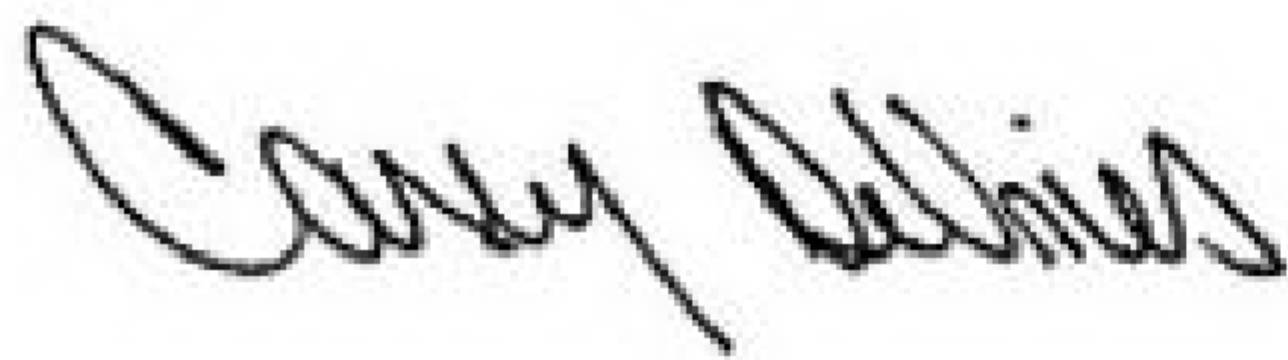
The Department of Health staff would like to schedule a conference call with Cure Home Health Inc. Please contact Casey DeVries at 651-201-5917 **on or before Tuesday, December 10, 2024**, to schedule the conference call.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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: SL34362015-0 On August 12, 2024, through, August 14, 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 three resident(s); three receiving services under the provider's Assisted Living Facility license. An immediate order for correction was identified on August 13, 2024, issued for SL34362015-0, tag identification 1290. During the survey, the facility took action to address the violation, however non-compliance remained, and the scope and level remained unchanged. On November 27, 2024, the content of the tag 0100 was amended, and the amended enforcement letter was sent to the licensee. The scope and level remain the same.	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 100	Continued From page 2 campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants resided on one side of the duplex, and the licensee did not have access to all areas of the facility. This practice resulted in a level two violation (a violation that did not harm a client'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 August 12, 2024, at approximately 12:00 p.m., the surveyor arrived at the licensee's address at 1509 East 22nd Street Minneapolis, MN. 55404, and observed a large building with two separate fire (address) numbers prominently displayed above two separate entrance doors. The door on the left, which led to an upstairs apartment labeled 1509 had a notification of electronic monitoring. The door on the right, labeled 1507, lead to a street level apartment and appeared to be a residential home. On August 12, 2024, at 12:59 p.m., during a tour of the facility, licensed assisted living director	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 100	Continued From page 3 (LALD)-A stated the lower level of the complex was a residential rental that was in no way associated with the licensee. Licensee's Application for Assisted Living License, submitted to the Minnesota Department of Health and signed on April 9, 2024, indicated on page 1, the physical address of the facility was 1509 East 22nd Street Minneapolis, MN. 55404. The application further indicated on page 5 and page 6, with a check mark, the licensee declared was the owner or authorized agent and attested to reading Minn. Stat. chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understood as the licensee was legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 480	Continued From page 4 prepared and served according to the Minnesota Food Code. 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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (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	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 510	Continued From page 5 review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one employee (licensed assisted living director (LALD)-A). 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) 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: On August 13, 2024, at 7:52 a.m., the surveyor observed LALD-A complete hand hygiene in the bathroom of the facility. LALD-A completed hand hygiene at the sink, and then using a roll of toilet paper in the bathroom to dry their hands. There were no additional rolls of toilet paper or rolls of paper towels available for use during hand hygiene. After drying hands using the toilet paper roll in the bathroom, LALD-A entered the kitchen of the facility to finish drying their hands and then put on clean gloves and prepared medications for a resident. On August 14, 2024, at 12:45 p.m., LALD-A stated there were usually paper towel rolls in the bathroom, but they just recently ran out. LALD-A stated they were not trained to use toilet paper during hand hygiene. On August 14, 2024, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated staff are to use paper	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 510	Continued From page 6 towels when drying hands after completing hand hygiene, and staff are expected to complete hand hygiene before and after gloving. The licensee's undated 8.01 Infection Control Policy, indicated "[Name of AL]'s infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities." The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated hand hygiene should be performed using an alcohol-based hand rub or wash with soap and water after contact with blood, body fluids, or contaminated surfaces. 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 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	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 550	Continued From page 7 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 the required information related to the grievance procedure. This had the potential to affect all 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) 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: On August 12, 2024, at 1:18 p.m., during a facility tour, the surveyor observed the common areas shared by residents, staff, and visitors as well as private rooms contained postings that listed the contact information for the regional Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities and Minnesota Adult Abuse Reporting Center. The postings failed to list the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. On August 12, 2024, at approximately 1:20 p.m.,	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 550	Continued From page 8 licensed assisted living director (LALD)-A stated they were not aware that the posting was missing the content and would update forms to reflect the statute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 680	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content. This had the potential to affect all 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: The licensee's emergency disaster preparedness plan dated August 1, 2021, lacked evidence of the following required content: - Policies and procedures to address to use volunteers and other emergency staffing strategies in its emergency plan; - Policies and procedures to address the role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Primary and alternate means of communicating with facility staff and Federal, State, tribal, regional & local emergency management agencies; and, - Policies and procedures on providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. On August 12, 2024, at 1:25 p.m., licensed	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 680	Continued From page 10 assisted living director (LALD)-A stated they believed the licensee's emergency preparedness plan to be complete in its content. The licensee's undated 9.01 Emergency Preparedness Plan - Appendix Z Compliance indicated the following: - It is the intent that [licensee], has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for three of three residents.	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 700	Continued From page 11 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) 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: On August 13, 2024, at 7:56 a.m., the surveyor observed licensed assisted living director (LALD)-A leave the electronic medical record (EMAR) open and unattended on a laptop computer from 7:58 a.m., to 8:01 a.m. in the common area of the facility. During this time a resident residing in the facility was observed wandering around in the facility. On August 13, 2024, at 8:22 a.m., clinical nurse supervisor (CNS)-B stated the expectation was to ensure the EMAR was secured at all times, and staff were trained to ensure HIPAA compliance. On August 13, 2024, at 8:32 a.m., LALD-A stated that normally a tablet was utilized during medication administration, and the device was carried with them during administration of medications to ensure HIPAA compliance. LALD-A stated that they had mistakenly left the monitor open due to change in habit. The licensee's undated Resident Records - Confidentiality policy indicated the following: - "Resident records will be kept confidential and locked in a secure area where only authorized staff of [name of company] have access to."	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 700	Continued From page 12 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the correct installation location of a smoke alarm in the common area next to	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 780	Continued From page 13 resident sleeping room 1 on the main level and interconnected smoke alarm in resident sleeping room 4 on the upper-level floor so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect resident(s) and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The findings include: On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the following: -The smoke alarm inside the resident sleeping room 4 (unoccupied) on the upper-level was not interconnected with the home's smoke alarm system so the actuation of one alarm would cause all alarms to operate. When the LALD-A tested the home's smoke alarm system by activation of the lower-level smoke alarm, the smoke alarm in room 4 failed to sound for proper notification inside the room. In addition, the smoke alarm inside resident sleeping room 4 when tested, sounded local. The RN-B visually	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 780	Continued From page 14 and verbally verified the finding inside room 4 at the time of discovery. Survey staff explained to the LALD-A and RN-B that when one alarm is activated, all required smoke alarms must operate and sound (interconnected) throughout the home. -The smoke alarm outside of resident room 1 was incorrectly installed on the wall at two (24 inches) feet below the ceiling on the main level floor. Survey staff explained to the RN-B that smoke alarms must be installed on the ceiling, or wall no more than 12 inches below the ceiling. The RN-B visually and verbally verified the finding at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient findings to the LALD-A and the RN-B, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 790	Continued From page 15 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation height of the portable fire extinguisher located on the main level floor. This had the potential to directly affect residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the portable fire extinguisher unit mounted next to the kitchen was incorrectly mounted at a height of 78 inches above the floor. The maximum height allowed by the state standard for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor. The LALD-A verified the finding at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient finding to the LALD-A and the	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 790	Continued From page 16 RN-B, and they understood and acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. 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 is 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).	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 800	Continued From page 17 The findings include: On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the following: -The resident sleeping room 1 egress window on the main level floor was not maintained for proper and ready operation for use including during an emergency. The RN-B attempted to open but had difficulty keeping the window open for measurement. The RN-B held up the window as survey staff took the clear opening measurements. -The permanently installed bathroom fan with the improper use of the electrical cord and plug connection was observed inside the main level bathroom. Survey staff explained to the LALD-A and the RN-B that the use of the electrical cord and plug connection is not allowed for permanent wiring of a bathroom fan. The LALD-A and the RN-B verified the finding at the time of discovery. The LALD-A stated they thought the work was permitted but they can have their electrician address it. -The licensee failed to provide sufficient lighting in the hallway between resident sleeping room 1 and the bathroom. Survey staff observed no light fixtures and electrical outlets in the hallway, and explained to the LALD-A and the RN-B that since there were no outlets in the hallway it would be difficult to install a lamp in the area and permanent lighting may be necessary. The LALD-A and RN-B confirmed the finding at the time of discovery. The LALD-A stated they could have the electrician look at addressing it. -The windowsills inside occupied resident	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 800	Continued From page 18 sleeping room 2 and the main level bathroom were filled with dirt and dust and needed to be cleaned. The RN-B visually verified the findings. -The door of the upper-level resident sleeping room 2 failed to latch when survey staff attempted to close the door multiple times. Survey staff noted that it can lock but lacked the latching hardware, and explained to the LALD-A that the door must also latch positively for fire/smoke protection during a fire emergency. The LALD-A and RN-B agreed to replace it with a standard door that would latch when closed. -Lack of readily accessible to the licensed home's water heater and boiler shut-off (control) valves during an emergency. The water heater and the boilers were located in a mechanical room on the lowest level floor of the two-unit duplex building. The access to the mechanical room was independent of the duplex through a separate door from the back of the building. The LALD-A stated that their maintenance staff has access to the lower-level floor and whom they call as necessary. However, at the time of the tour, the LALD-A stated the maintenance staff was not available, and while survey staff waited for approximately ten minutes for the LALD-A to ask the tenant of the other unlicensed unit (1507) to open the door. The above deficient finding was verbally and visually verified by the LALD-A at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient findings to the LALD-A and the RN-B, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 800	Continued From page 19 days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 810	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. 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) 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: On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the posted fire evacuation floor plans/diagrams indicated the following: -The posted diagrams did not include room numbers for each resident bedroom. Evacuation layout diagrams must include the location and resident sleeping room numbers. The LALD-A verified the finding and agreed to add the room numbers on the diagrams at the time of discovery. - The inaccurate number and the location of resident sleeping rooms on the upper-level floor.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 810	Continued From page 21 The posted evacuation floor diagram for the upper-level floor showed a storage room at the end of the hallway labeled as a bedroom when during the tour, the LALD-A and the RN-B both stated that it was a storage room and used as a storage room. Furthermore, the room numbers did not match the numbers shown on the posted evacuation diagram. Survey staff explained to the LALD-A that the resident room numbers on the evacuation floor plans are required to accurately match the numbers on the resident room doors to provide the occupant's direction in the event of a fire or similar emergency. The LALD-A verified the findings and initiated corrections on the posted diagrams. On August 14, 2024, at approximately 3:45 p.m., document and record review and interview with the RN-B, on the home's fire safety and evacuation plan, 9.06, Fire Policy, dated "XX-XX-XXXX" and another handwritten fire procedures with no written date, and related training policies, procedures, and records indicated the following: -A review of the emergency preparedness plan (EPP) binder including the home ' s fire safety plan, also indicated a discrepancy in the resident sleeping rooms numbering between the evacuation floor diagrams and the actual labeling on the sleeping room doors. The survey staff explained to the RN-B that these evacuation diagrams must be updated. -Document review indicated the licensee had multiple fire safety plans in the EEP binder confusing staff and visitors. The policy/procedure 9.06, Fire Safety Policy (xx-xx-xxxx) procedure with handwritten writing for "Cure Home" that included non-site specific procedures for fire safety with sprinklers and magnetic door holders	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 810	Continued From page 22 which the home did not have, and another separate plan that was all handwritten fire safety procedure (no date). The RN-B verified the finding and stated that the 9.06, Fire Safety policy is just a policy, and the handwritten fire safety is their actual procedure. -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. End of 8/15 to send to CMT -A document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training for calendar years 2022 and 2023. Survey staff received training records to date for 2024. During an interview, RN-B stated that she was aware of the requirement that started in 2021 but did not have records or logs available for 2022 and 2023. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year for calendar years 2022 and 2023. During an interview, RN-B stated that no records were available for 2022 and 2023. -Record review indicated the licensee failed to provide the minimum required employee fire	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 810	Continued From page 23 evacuation drills twice per year, per shift with at least one evacuation drill every other month. Record review indicated that evacuation drills were correctly conducted to date for the year 2024; for the calendar year 2023, the licensee performed one evacuation drill for their late shift out of the six evacuation drills performed for a two work-shift-day; and for the calendar year 2022, all six evacuation drills were in their day shift and no late shifts were performed for a two work-shift-day. The RN-B verified the findings at the time of discovery. Survey staff explained to the RN-B that they should rotate shifts and times to meet the requirement and must perform employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. The above deficient findings were verified by the RN-B during the interview. Additional documentation on unique or unusual resident needs for movement or evacuation during a fire or similar emergency was provided by the LALD-A via email at 5:18 p.m. on August 15, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 910	Continued From page 24 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 the residents). The findings include: On August 13, 2024, at 8:55 a.m., licensed assisted living director (LALD)-A stated that the contract utilized for R1 was the same contract utilized by all residents within the facility. The licensee's Resident Contract for Assisted Living dated January 1, 2024, contained the Health Facility Identification (HFID) number of an affiliated facility and lacked HFID number belonging to the licensee. On August 13, 2023, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated the HFID listed in the contract belonged to a facility they managed. CNS-B stated all contracts in the facility would	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 910	Continued From page 25 contain the same error. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01290 SS=H	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for three of five employees (unlicensed personnel (ULP)-C, ULP-D, and ULP-E). 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	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
01290	Continued From page 26 serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began employment with the licensee on October 20, 2020, to provide care and services under the licensee's Assisted Living license. ULP-C's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page (a web-based system used for submitting background study requests to the Department of Human Services). ULP-D ULP-D began employment with the licensee on September 1, 2021, to provide care and services under the licensee's Assisted Living license. ULP-D's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page. ULP-E ULP-E began employment with the licensee on February 5, 2022, to provide care and services under the licensee's Assisted Living license. ULP-E's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
01290	Continued From page 27 On August 13, 2024, at 1:39 p.m., licensed assisted living director (LALD)-A stated that ULP-C worked last night from 12:00 a.m. to 8:00 a.m., on August 13, 2024, with no supervision, and ULP-E worked the evening shift last night unsupervised from 4:00 p.m. to 12:00 a.m. On August 13, 2024, at 1:44 p.m., LALD-A stated that they were unaware that the background studies had expired and stated they did not know how it was missed. On August 13, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
01290	Continued From page 28 emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's undated 4.02 Background Studies policy, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Name of AL] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the facility took action to address the violation, however non-compliance remained, and the scope and level remained unchanged. TIME PERIOD FOR CORRECTION: Two (2) days	01290			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 24, 2024

Licensee

Cure Home Health Inc
1509 East 22nd Street
Minneapolis, MN 55404

RE: Project Number(s) SL34362015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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 hearing must be in writing and received by the Department of Health within 15 business days of the 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

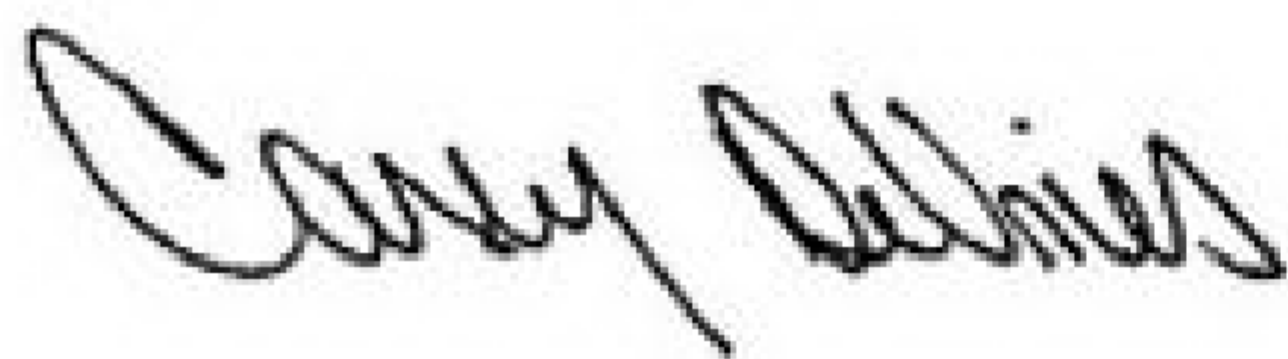
The Department of Health staff would like to schedule a conference call with Cure Home Health Inc. Please contact Casey DeVries at 651-201-5917 **on or before Tuesday, October 29, 2024**, to schedule the conference call.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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: SL34362015-0 On August 12, 2024, through, August 14, 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 three resident(s); three receiving services under the provider's Assisted Living Facility license. An immediate order for correction was identified on August 13, 2024, issued for SL34362015-0, tag identification 1290. During the survey, the facility took action to address the violation, however non-compliance remained, and the scope and level remained unchanged.	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.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to obtain accurate licensure when the licensee applied for licensure for a single residential dwelling, despite sharing one roof with an adjoining duplex home, without having an approved two-hour fire barrier wall separating the two dwellings. This practice resulted in a level two violation (a violation that did not harm a client'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 August 12, 2024, at approximately 12:00 p.m., the surveyor arrived at the licensee's address at 1509 East 22nd Street Minneapolis, MN. 55404, and observed a large building with two separate fire (address) numbers prominently displayed above two separate entrance doors. The door on the left, which led to an upstairs apartment labeled 1509 had a notification of electronic monitoring. The door on the right, labeled 1507, lead to a street level apartment and appeared to be a residential home. On August 12, 2024, at 12:59 p.m., during a tour of the facility, licensed assisted living director (LALD)-A stated the lower level of the complex was a residential rental that was in no way	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 100	Continued From page 3 associated with the licensee. Licensee's Application for Assisted Living License, submitted to the Minnesota Department of Health and signed on April 9, 2024, indicated on page 1, the physical address of the facility was 1509 East 22nd Street Minneapolis, MN. 55404. The application further indicated on page 5 and page 6, with a check mark, the licensee declared was the owner or authorized agent and attested to reading Minn. Stat. chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understood as the licensee was legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 480	Continued From page 4 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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (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 effective infection control program	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 510	Continued From page 5 that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one employee (licensed assisted living director (LALD)-A). 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) 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: On August 13, 2024, at 7:52 a.m., the surveyor observed LALD-A complete hand hygiene in the bathroom of the facility. LALD-A completed hand hygiene at the sink, and then using a roll of toilet paper in the bathroom to dry their hands. There were no additional rolls of toilet paper or rolls of paper towels available for use during hand hygiene. After drying hands using the toilet paper roll in the bathroom, LALD-A entered the kitchen of the facility to finish drying their hands and then put on clean gloves and prepared medications for a resident. On August 14, 2024, at 12:45 p.m., LALD-A stated there were usually paper towel rolls in the bathroom, but they just recently ran out. LALD-A stated they were not trained to use toilet paper during hand hygiene. On August 14, 2024, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated staff are to use paper towels when drying hands after completing hand hygiene, and staff are expected to complete hand	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 510	Continued From page 6 hygiene before and after gloving. The licensee's undated 8.01 Infection Control Policy, indicated "[Name of AL]'s infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities." The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated hand hygiene should be performed using an alcohol-based hand rub or wash with soap and water after contact with blood, body fluids, or contaminated surfaces. 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 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	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 550	Continued From page 7 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 the required information related to the grievance procedure. This had the potential to affect all 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) 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: On August 12, 2024, at 1:18 p.m., during a facility tour, the surveyor observed the common areas shared by residents, staff, and visitors as well as private rooms contained postings that listed the contact information for the regional Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities and Minnesota Adult Abuse Reporting Center. The postings failed to list the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. On August 12, 2024, at approximately 1:20 p.m., licensed assisted living director (LALD)-A stated they were not aware that the posting was missing	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 550	Continued From page 8 the content and would update forms to reflect the statute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 680	Continued From page 9 Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content. This had the potential to affect all 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: The licensee's emergency disaster preparedness plan dated August 1, 2021, lacked evidence of the following required content: - Policies and procedures to address to use volunteers and other emergency staffing strategies in its emergency plan; - Policies and procedures to address the role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Primary and alternate means of communicating with facility staff and Federal, State, tribal, regional & local emergency management agencies; and, - Policies and procedures on providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. On August 12, 2024, at 1:25 p.m., licensed assisted living director (LALD)-A stated they believed the licensee's emergency preparedness	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 680	Continued From page 10 plan to be complete in its content. The licensee's undated 9.01 Emergency Preparedness Plan - Appendix Z Compliance indicated the following: - It is the intent that [licensee], has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for three of three residents. This practice resulted in a level two violation (a	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 700	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On August 13, 2024, at 7:56 a.m., the surveyor observed licensed assisted living director (LALD)-A leave the electronic medical record (EMAR) open and unattended on a laptop computer from 7:58 a.m., to 8:01 a.m. in the common area of the facility. During this time a resident residing in the facility was observed wandering around in the facility. On August 13, 2024, at 8:22 a.m., clinical nurse supervisor (CNS)-B stated the expectation was to ensure the EMAR was secured at all times, and staff were trained to ensure HIPAA compliance. On August 13, 2024, at 8:32 a.m., LALD-A stated that normally a tablet was utilized during medication administration, and the device was carried with them during administration of medications to ensure HIPAA compliance. LALD-A stated that they had mistakenly left the monitor open due to change in habit. The licensee's undated Resident Records - Confidentiality policy indicated the following: - "Resident records will be kept confidential and locked in a secure area where only authorized staff of [name of company] have access to." No further information provided.	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 700	Continued From page 12	0 700			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the correct installation location of a smoke alarm in the common area next to resident sleeping room 1 on the main level and interconnected smoke alarm in resident sleeping	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 780	Continued From page 13 room 4 on the upper-level floor so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect resident(s) and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The findings include: On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the following: -The smoke alarm inside the resident sleeping room 4 (unoccupied) on the upper-level was not interconnected with the home's smoke alarm system so the actuation of one alarm would cause all alarms to operate. When the LALD-A tested the home's smoke alarm system by activation of the lower-level smoke alarm, the smoke alarm in room 4 failed to sound for proper notification inside the room. In addition, the smoke alarm inside resident sleeping room 4 when tested, sounded local. The RN-B visually and verbally verified the finding inside room 4 at the time of discovery. Survey staff explained to	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 780	Continued From page 14 the LALD-A and RN-B that when one alarm is activated, all required smoke alarms must operate and sound (interconnected) throughout the home. -The smoke alarm outside of resident room 1 was incorrectly installed on the wall at two (24 inches) feet below the ceiling on the main level floor. Survey staff explained to the RN-B that smoke alarms must be installed on the ceiling, or wall no more than 12 inches below the ceiling. The RN-B visually and verbally verified the finding at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient findings to the LALD-A and the RN-B, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 790	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation height of the portable fire extinguisher located on the main level floor. This had the potential to directly affect residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the portable fire extinguisher unit mounted next to the kitchen was incorrectly mounted at a height of 78 inches above the floor. The maximum height allowed by the state standard for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor. The LALD-A verified the finding at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient finding to the LALD-A and the RN-B, and they understood and acknowledged the finding.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 790	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. 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 is 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:	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 800	Continued From page 17 On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the following: -The resident sleeping room 1 egress window on the main level floor was not maintained for proper and ready operation for use including during an emergency. The RN-B attempted to open but had difficulty keeping the window open for measurement. The RN-B held up the window as survey staff took the clear opening measurements. -The permanently installed bathroom fan with the improper use of the electrical cord and plug connection was observed inside the main level bathroom. Survey staff explained to the LALD-A and the RN-B that the use of the electrical cord and plug connection is not allowed for permanent wiring of a bathroom fan. The LALD-A and the RN-B verified the finding at the time of discovery. The LALD-A stated they thought the work was permitted but they can have their electrician address it. -The licensee failed to provide sufficient lighting in the hallway between resident sleeping room 1 and the bathroom. Survey staff observed no light fixtures and electrical outlets in the hallway, and explained to the LALD-A and the RN-B that since there were no outlets in the hallway it would be difficult to install a lamp in the area and permanent lighting may be necessary. The LALD-A and RN-B confirmed the finding at the time of discovery. The LALD-A stated they could have the electrician look at addressing it. -The windowsills inside occupied resident sleeping room 2 and the main level bathroom were filled with dirt and dust and needed to be	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 800	Continued From page 18 cleaned. The RN-B visually verified the findings. -The door of the upper-level resident sleeping room 2 failed to latch when survey staff attempted to close the door multiple times. Survey staff noted that it can lock but lacked the latching hardware, and explained to the LALD-A that the door must also latch positively for fire/smoke protection during a fire emergency. The LALD-A and RN-B agreed to replace it with a standard door that would latch when closed. -Lack of readily accessible to the licensed home's water heater and boiler shut-off (control) valves during an emergency. The water heater and the boilers were located in a mechanical room on the lowest level floor of the two-unit duplex building. The access to the mechanical room was independent of the duplex through a separate door from the back of the building. The LALD-A stated that their maintenance staff has access to the lower-level floor and whom they call as necessary. However, at the time of the tour, the LALD-A stated the maintenance staff was not available, and while survey staff waited for approximately ten minutes for the LALD-A to ask the tenant of the other unlicensed unit (1507) to open the door. The above deficient finding was verbally and visually verified by the LALD-A at the time of discovery. On August 14, 2024, at approximately 4:30 p.m., during an interview, survey staff explained the above deficient findings to the LALD-A and the RN-B, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 810	Continued From page 19	0 810			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 810	Continued From page 20 Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. 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) 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: On August 14, 2024, from approximately, 2:15 p.m. to 3:45 p.m., survey staff toured the home with the registered nurse (RN)-B and the licensed assisted living director (LALD)-A. The LALD-A joined the tour at 2:30 p.m. During the tour, survey staff observed the posted fire evacuation floor plans/diagrams indicated the following: -The posted diagrams did not include room numbers for each resident bedroom. Evacuation layout diagrams must include the location and resident sleeping room numbers. The LALD-A verified the finding and agreed to add the room numbers on the diagrams at the time of discovery. - The inaccurate number and the location of resident sleeping rooms on the upper-level floor. The posted evacuation floor diagram for the upper-level floor showed a storage room at the	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 810	Continued From page 21 end of the hallway labeled as a bedroom when during the tour, the LALD-A and the RN-B both stated that it was a storage room and used as a storage room. Furthermore, the room numbers did not match the numbers shown on the posted evacuation diagram. Survey staff explained to the LALD-A that the resident room numbers on the evacuation floor plans are required to accurately match the numbers on the resident room doors to provide the occupant's direction in the event of a fire or similar emergency. The LALD-A verified the findings and initiated corrections on the posted diagrams. On August 14, 2024, at approximately 3:45 p.m., document and record review and interview with the RN-B, on the home's fire safety and evacuation plan, 9.06, Fire Policy, dated "XX-XX-XXXX" and another handwritten fire procedures with no written date, and related training policies, procedures, and records indicated the following: -A review of the emergency preparedness plan (EPP) binder including the home ' s fire safety plan, also indicated a discrepancy in the resident sleeping rooms numbering between the evacuation floor diagrams and the actual labeling on the sleeping room doors. The survey staff explained to the RN-B that these evacuation diagrams must be updated. -Document review indicated the licensee had multiple fire safety plans in the EEP binder confusing staff and visitors. The policy/procedure 9.06, Fire Safety Policy (xx-xx-xxxx) procedure with handwritten writing for "Cure Home" that included non-site specific procedures for fire safety with sprinklers and magnetic door holders which the home did not have, and another separate plan that was all handwritten fire safety	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404		
(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
0 810	Continued From page 22 procedure (no date). The RN-B verified the finding and stated that the 9.06, Fire Safety policy is just a policy, and the handwritten fire safety is their actual procedure. -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. End of 8/15 to send to CMT -A document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training for calendar years 2022 and 2023. Survey staff received training records to date for 2024. During an interview, RN-B stated that she was aware of the requirement that started in 2021 but did not have records or logs available for 2022 and 2023. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year for calendar years 2022 and 2023. During an interview, RN-B stated that no records were available for 2022 and 2023. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 810	Continued From page 23 Record review indicated that evacuation drills were correctly conducted to date for the year 2024; for the calendar year 2023, the licensee performed one evacuation drill for their late shift out of the six evacuation drills performed for a two work-shift-day; and for the calendar year 2022, all six evacuation drills were in their day shift and no late shifts were performed for a two work-shift-day. The RN-B verified the findings at the time of discovery. Survey staff explained to the RN-B that they should rotate shifts and times to meet the requirement and must perform employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. The above deficient findings were verified by the RN-B during the interview. Additional documentation on unique or unusual resident needs for movement or evacuation during a fire or similar emergency was provided by the LALD-A via email at 5:18 p.m. on August 15, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable;	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 910	Continued From page 24 (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 the residents). The findings include: On August 13, 2024, at 8:55 a.m., licensed assisted living director (LALD)-A stated that the contract utilized for R1 was the same contract utilized by all residents within the facility. The licensee's Resident Contract for Assisted Living dated January 1, 2024, contained the Health Facility Identification (HFID) number of an affiliated facility and lacked HFID number belonging to the licensee. On August 13, 2023, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated the HFID listed in the contract belonged to a facility they managed. CNS-B stated all contracts in the facility would contain the same error.	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
0 910	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01290 SS=H	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for three of five employees (unlicensed personnel (ULP)-C, ULP-D, and ULP-E). 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 pattern scope (when more than a	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
01290	Continued From page 26 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began employment with the licensee on October 20, 2020, to provide care and services under the licensee's Assisted Living license. ULP-C's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page (a web-based system used for submitting background study requests to the Department of Human Services). ULP-D ULP-D began employment with the licensee on September 1, 2021, to provide care and services under the licensee's Assisted Living license. ULP-D's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page. ULP-E ULP-E began employment with the licensee on February 5, 2022, to provide care and services under the licensee's Assisted Living license. ULP-E's background study affiliated to HFID 34362, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page. On August 13, 2024, at 1:39 p.m., licensed	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
01290	Continued From page 27 assisted living director (LALD)-A stated that ULP-C worked last night from 12:00 a.m. to 8:00 a.m., on August 13, 2024, with no supervision, and ULP-E worked the evening shift last night unsupervised from 4:00 p.m. to 12:00 a.m. On August 13, 2024, at 1:44 p.m., LALD-A stated that they were unaware that the background studies had expired and stated they did not know how it was missed. On August 13, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER CURE HOME HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 EAST 22ND STREET MINNEAPOLIS, MN 55404			
(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
01290	Continued From page 28 guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's undated 4.02 Background Studies policy, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Name of AL] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the facility took action to address the violation, however non-compliance remained, and the scope and level remained unchanged. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

Type: Full
Date: 08/13/24
Time: 13:36:25
Report: 1036241155

Food and Beverage Establishment Inspection Report

Page 1

Location:

Cure Home Health Inc
1509 East 22nd Street
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0039062
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122364577
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.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

OBSERVED AN OPENED CONTAINER OF MILK AND MAYO IN THE FRIDGE THAT WERE OVER 41 DEGREES F *SEE NOTES. ITEMS DISCARDED ON SITE AND UNIT TEMPERATURE CONTROLLER WAS TURNED DOWN.

Corrected on Site

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE CFPM WAS NOT POSTED IN ESTABLISHMENT. ISSUE CORRECTED ON SITE.

Corrected on Site

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED A COUPLE PANS STORED IN THE KITCHEN OVEN WITH SEVERE SCRATCHING MAKING THEM NOT EASILY CLEANABLE. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

Type: Full
Date: 08/13/24
Time: 13:36:25
Report: 1036241155
Cure Home Health Inc

Food and Beverage Establishment Inspection Report

Page 2

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED A CHIPPED MORTAR AND PESTLE IN THE KITCHEN CABINET. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

OBSERVED SOME EXPOSED ABSORBENT WOOD ON THE EDGES OF COUNTERTOPS IN THE KITCHEN. REPAIR/REPLACE SO SURFACE IS COMPLIANT WITH ABOVE RULE.

Comply By: 09/03/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED RESIDUE BUILD UP ON THE VENT HOOD ABOVE THE OVEN AND CRUMBS/DEBRIS THROUGHOUT THE KITCHEN CABINETS/DRAWERS. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 174 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit

Location: SANITIZER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 47 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: Yes

Process/Item: Cold Hold/MAYO

Temperature: 48 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: Yes

Process/Item: Ambient Temp

Temperature: 45 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: Yes

Type: Full
Date: 08/13/24
Time: 13:36:25
Report: 1036241155
Cure Home Health Inc

Food and Beverage Establishment
Inspection Report

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE (~20 MINS AFTER TEMPERATURE ADJUSTED)
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	5

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ZACH MORTH. INSPECTION CONDUCTED IN PRESENCE OF ZAHRA YOUSUF, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD THREE RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: 08/13/24
Time: 13:36:25
Report: 1036241155
Cure Home Health Inc

Food and Beverage Establishment Inspection Report

Page 4

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

I acknowledge receipt of the inspection report number 1036241155 of 08/13/24.

Certified Food Protection Manager: ABDIRASHID A. SAID

Certification Number: FM114520 Expires: 12/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

ZAHRA YOUSUF
PERSON IN CHARGE

Signed: _____

Jeff Johanson