Electronically Delivered

July 5, 2024

Licensee
Cure Home Health Inc
508 Van Buren Avenue
Saint Paul, MN 55103

RE: Project Number(s) SL37458015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37458	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURE HOME HEALTH INC	508 VAN BUREN AVENUE SAINT PAUL, MN 55103

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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: SL37458015 On June 10, 2024, through June 12, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents receiving services under the provider's Assisted Living license.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted as required in one of one building. This had the potential to affect all four residents 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) and was issued at a widespread scope (when problems are pervasive	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility license. The facility was licensed for a capacity of five residents and had a current census of four residents. On June 10, 2024, at approximately 10:45 a.m., during a tour of the facility with licensed assisted living director/unlicensed personnel (LALD/ULP)-A and clinical nurse supervisor (CNS)-C, the surveyor did not see the staffing plan posted in a central location. On June 10, 2024, at 11:01 a.m., LALD/ULP-A and CNS-C showed the surveyor the staffing plan posted on a wall behind the desk in the office located on the lower floor of the split level home. The door to the office had a sign on it noting: -Hours of Business, Monday-Friday 9 a.m. - 5 p.m. -Medication room: keep this door closed at all times. Directly after the above observation LALD/ULP-A confirmed the staffing plan was not posted in a central location as required. LALD/ULP-A later posted a copy of the staffing plan in the upstairs common's area, near the kitchen. CNS-C stated call it (staffing plan) what it is, "the schedule", it is not a "staffing plan." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each	0 470		

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0 470	Continued From page 3 work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The licensee's Staffing policy dated August 1, 2021, noted the schedule was posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
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	0 480		

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0 480	Continued From page 4 review, the licensee failed to ensure food was 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 June 11, 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		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 5 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of two employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on February 17, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 10, 2024, at 10:12 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include documentation of all required training to include: -annual review of provider's policies and	0 650		

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0 650	Continued From page 6 procedures. On June 10, 2024, at 1:38 p.m., CNS-C stated she reviewed the facilities policies and procedures but confirmed CNS-C's record did not include the above required training. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Employee Records policy dated August 1, 2021, noted employee records for each person would include: -records of all training and in-service education	0 650		

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0 650	Continued From page 7 required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and TB symptom screening for two of three	0 660		

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0 660	Continued From page 8 employees (licensed assisted living director/unlicensed personnel (LALD/ULP)-A, ULP-B). 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: The facility's TB risk assessment was completed on February 1, 2024, and was determined to be a low risk level. LALD/ULP-A LALD/ULP-A was hired on August 1, 2021, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On June 11, 2024, 8:16 a.m., the surveyor observed LALD/ULP-A prepare R1's Lantus (long-acting insulin) pen for administration. LALD/ULP-A's employee record included documentation of a TB screening completed on August 1, 2021, and a chest x-ray completed on February 25, 2021. LALD/ULP-A's record did not include a previous TB test or anything to indicated why LALD/ULP-A had a chest x-ray in his employee record. In addition, the chest x-ray was completed 157 days from hire. On June 10, 2024, at 2:31 p.m., LALD/ULP-A stated he was not aware of the need to have	0 660		

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0 660	Continued From page 9 another chest x-ray or previous TB test in his record. LALD/ULP-A stated he had the BCG (Bacillus Calmette-Guerin/vaccine used against TB) vaccination. LALD/ULP-A and CNS-C confirmed LALD/ULP-A's record did not include required information. ULP-B ULP-B was hired on April 8, 2024, to provide direct care to the licensee's residents. R1's medication administration record (MAR) dated June 1, 2024, through June 11, 2024, indicated ULP-B administered R1's morning medication on June 1, June 2, June 9, and June 10, 2024. On June 12, 2024, at 10:10 a.m., CNS-C stated ULP-B's employee file did not contain a TB symptom screening. CNS-C said ULP-B went to the clinic to have the TB blood test completed. CNS-C stated "I assure you" the clinic would not do the TB blood test without first doing a TB screening. LALD/ULP-A and CNS-C said they could call the clinic and get ULP-B's TB screening completed at the clinic. CNS-C confirmed ULP-B's employee file did not contain a TB symptom screening as required. The licensee's Tuberculosis Screening policy dated June 2021, noted new staff would have an IGRA (interferon-gamma release assays/ test used to check for TB infection) blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No staff would be permitted to begin work where the work involved sharing the air space with residents until the negative results of the first Mantoux were read and documented or a negative IGRA blood test result was received and	0 660		

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0 660	Continued From page 10 documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
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: Based on observation, interview, and record	0 680		

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0 680	Continued From page 11 review, the licensee failed to have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the 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 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: On June 10, 2024, at 10:33 a.m., during the entrance conference, licensed assisted living director/unlicensed personnel (LALD/ULP)-A and clinical nurse supervisor (CNS)-C stated the EPP binder was kept in the office, in the lower level of a spilt entry home. On June 10, 2024, at approximately 11:00 a.m., during a tour of the facility the surveyor observed some contact phone numbers posted in the common's area of the upper level. On June 10, 2024, at 11:16 a.m., the EPP was reviewed with CNS-C and LALD/ULP-A. There was a form in the front of the EPP binder, Emergency Preparedness in Assisted Living, date of review/update, that was blank. LALD/ULP-A stated the EPP was last reviewed in February 2024. LALD/ULP-A wrote down the date of February 5, 2024 as the date the EPP was reviewed, at that time.	0 680		

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(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 12 The licensee's EPP last reviewed February 2024, failed to include the following: -a complete communication plan -a risk assessment that identified all required areas -identification of the at-risk population needs like maintaining independence, communication, transportation, supervision, and medical care -procedures for tracking of staff and residents. On June 10, 2024, at 11:23 a.m., LALD/ULP-A and CNS-C stated they need to do "the homework" on the EPP. CNS-C added it is very complex and they (LALD/ULP-A and CNS-C) would go back through the EPP. CNS-C and LALD/ULP-A confirmed the EPP was missing the above information. In addition, CNS-C confirmed the EPP was not in a prominent area at the time of the survey entrance, adding there was no signage of the EPP's location posted in the facility. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. The licensee's Emergency Preparedness policy dated August 1, 2021, noted (name of facility) would have an identified plan in place to assure that safety and well-being of residents and staff	0 680		

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0 680	Continued From page 13 during periods of an emergency or disaster that disrupted services. The policy referenced the CMS (Centers for Medicare & Medicaid Services) State Operation Manual Appendix Z: MN Rules 4659.0100. -the Emergency Disaster Plan is prominently posted on each floor of the facility -emergency occurrences include, but are not limited to: natural disasters, such as tornados or severe winter storms, communication system failure, epidemics, terrorist activities, facility damage, such as fire or flooding -the EPP would be reviewed/updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	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 This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 14 Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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 potential to affect a large portion or all of the residents). The findings include: On a facility tour on June 12, 2024, at 1:30 p.m., with licensed assisted living director/ unlicensed personnel (LALD/ULP)-A, and clinical nurse supervisor (CNS)-C, it was observed that the required fire extinguishers provided on both levels of the facility had a 1-A:10-BC classification. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on June 12, 2024, at 1:35 p.m., LALD/ULP-A, and CNS-C, verified this deficient	0 790		

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0 790	Continued From page 15 finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 800 SS=E	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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 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). Findings include:	0 800		

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0 800	Continued From page 16 On a facility tour on June 12, 2024, at 1:45 p.m., with licensed assisted living director/ unlicensed personnel (LALD/ULP)-A, and clinical nurse supervisor (CNS)-C, the surveyor made the following observations of facility hazards and disrepair: The weather seal on the front main exit door was damaged and did not seal to the door allowing light and air to pass through. The trim was coming off at the top interior of the front main exit door. The screen had a 12-inch by 12-inch hole in it at the bottom of the back patio door screen door. There was water damage causing the wood to swell and come apart on the left side of the vanity sink cabinet in the upstairs bathroom. During a facility tour on June 12, 2024, at 1:50 p.m., LALD/ULP-A, and CNS-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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;	0 810		

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0 810	Continued From page 17 (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: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly 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	0 810		

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0 810	Continued From page 18 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 June 12, 2024, at 12:55 p.m., licensed assisted living director/ unlicensed personnel (LALD/ULP)-A, and clinical nurse supervisor (CNS)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The accurate number and location of resident sleeping rooms on the upper level. The numbers identifying the resident rooms on the posted evacuation map were 1 and 2. The numbers on the doors of the resident rooms were number 3 and 4. The resident room numbers on the evacuation floor plan are required to accurately match the numbers on the resident room doors in order to provide the occupants direction in the event of a fire or similar emergency. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to provide specific updated procedures for employees to take in the event of a fire or similar emergency. The plan provided was from a consultant with a general format but was not	0 810		

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0 810	Continued From page 19 updated for this facility. The FSEP did not identify specific fire protection actions for residents evident by not providing procedures for residents to take in the event of a fire or similar emergency in writing and available in the plan. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include specific evacuation status/ unique needs for evacuation for each resident in writing and available with the FSEP. During an interview on June 12, 2024, at 1:15 p.m., LALD/ULP-A, and CNS-C, stated the FSEP was not updated to include the required information listed above. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation training was completed by employees and required and specific to this facility FSEP. Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation resident training based on this facility FSEP was provided as required. During an interview on June 12, 2024, at 1:20 p.m., LALD/ULP-A, and CNS-C, stated	0 810		

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0 810	Continued From page 20 documentation was not available for training completed by employees and offered to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide complete written instructions in the resident record for delegated tasks for one of two residents (R1) for a diabetic diet. 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	01420		

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01420	Continued From page 21 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses include diabetes, forgetfulness with short-term memory. R1's service plan reviewed and updated June 1, 2024, included: prepare modified diet -diabetic diet/low carb (carbohydrate) & low sugar. R1's prescriber's order dated June 28, 2023, to June 28, 2024, included: -diabetic supplies -blood sugar check three times a day. R1's assessment dated March 1, 2024, included: -special diet: none -nursing diagnosis: diet not compliant, type two diabetic, elevated blood sugar at time. R1's UDALSA (Uniform Disclosure of Amenities and Services) dated June 2, 2023, included: -therapeutic diets: diabetic or calorie controlled -carbohydrate intake/tracking. On June 11, 2024, at 9:03 a.m., clinical nurse supervisor (CNS)-C asked R1 if she would like a cup of coffee. R1 replied yes, with one creamer and two sugars. On June 11, 2024, at 9:09 a.m., CNS-C served R1 a cup of coffee as requested by R1. On June 11, 2024, at 12:20 p.m., surveyor	01420		

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01420	Continued From page 22 reviewed R1's service plan with CNS-C. The surveyor requested the instructions/directions for R1's diabetic diet in R1's record. CNS-C stated there were no instructions in R1's record for diet. CNS-C said R1 did not have a "doctor's order" for a diet. CNS-C said, "it is common sense. I train my staff on diabetic diets." CNS-C added staff would know R1 was diabetic and R1 should be on a diabetic diet because R1 had scheduled blood sugar checks and R1 "got" insulin. CNS-C confirmed R1's record did not contain instructions/directions for R1's diabetic diet. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, noted, the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 23 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 24 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained orientation to assisted living facility licensing for one of three employees, (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on April 8, 2024, to provide direct care to the licensee's residents. R1's medication administration record (MAR) dated June 1, 2024, through June 11, 2024, indicated ULP-B administered R1's morning medication on June 1, June 2, June 9, and June 10, 2024. ULP-B's employee record lacked evidence of completing the following assisted living orientation before providing assisted living services to the licensee's residents: -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01470		

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01470	Continued From page 25 On June 12, 2024, at 10:13 a.m., clinical nurse supervisor (CNS)-C reviewed ULP-B's training transcript. CNS-C stated she did not see evidence of person-centered training completion in ULP-B's record. CNS-C confirmed ULP-B's record did not include evidence the required training was completed. The licensee's Employee Records policy dated August 1, 2021, noted employee records for each person would include: -records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 26 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of three residents (R1, R2). 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: R1 R1 began receiving services on June 2, 2023. R1's diagnoses include diabetes, forgetfulness with short-term memory, and PTSD (post-traumatic stress disorder/mental health disorder that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations).	01620		

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	37458	A. BUILDING: _____ B. WING _____	06/12/2024

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01620	Continued From page 27 R1's service plan reviewed and updated June 1, 2024, included: -medication administration three times a day and as needed (PRN). On June 11, 2024, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-A test R1's blood sugar level and prepare and administer R1's morning medication. R1's record included an assessment dated December 1, 2023. R1's record included a 90-day assessment dated March 1, 2024. (91 days between assessments). R1's record included an assessment dated June 1, 2024. (92 days between assessments). R1's record did not include reassessments that did not exceed 90 days between assessments. On June 11, 2024, at 12:42 p.m., clinical nurse supervisor (CNS)-C stated, "it is a calendar thing." CNS-C confirmed R1's assessments were not completed as required. R2 R2 began receiving services on December 22, 2021. R2's diagnoses include depression and hypertension (HTN/high blood pressure). R2's service plan reviewed and updated May 7, 2024, indicated R2 received medication administration three times a day and PRN. On June 11, 2024, at 9:33 a.m., the surveyor	01620		

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01620	Continued From page 28 observed ULP-A administer R2's morning medication. R2's record included an assessment dated August 1, 2023. R2's record included an assessment dated November 3, 2023. (94 days between assessments). R2's record did not include reassessments which did not exceed 90 days between assessments. On June 11, 2024, at approximately 1:45 p.m., the surveyor and CNS-C reviewed R2's assessments. CNS-C stated she did not have another assessment that had been completed between August 2023 and November 2023, as required. On June 11, 2024, at 2:01 p.m., CNS-C stated she is aware assessments are required every 90 days, adding she used to use sticky notes to alert her of upcoming assessments. CNS-C confirmed assessments were not completed as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception	01620		

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01620	Continued From page 29 under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Assessment Schedules policy dated August 1, 2021, noted ongoing resident reassessment and monitoring would be done as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01750		

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01750	Continued From page 30 registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R1, R2). 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: R1 R1's diagnoses include forgetfulness with short-term memory. diabetes, and PTSD (post-traumatic stress disorder/mental health disorder that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.) R1's service plan reviewed and updated June 1, 2024, included: -medication administration three times a day and as needed (PRN). R1's Individualized Medication Management Plan form reviewed and updated June 1, 2024, included: -medication reminders by staff -assistance with self-administration of medication (may include providing food/fluids) by facility staff -medication administration by facility staff. -documentation related to medications are	01750		

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01750	Continued From page 31 located: on the MAR (medication administration record). R1's prescriber's orders dated September 27, 2023, included: -Lantus Solostar (long-acting insulin/diabetes) 100 units/milliliter (ml) inject 35 units subcutaneously (under the skin/ fatty tissue). R1's MAR dated June 1, 2024 through June 10, 2024, included: -Lantus Solostar 100 units/ml subcutaneous solution pen injection, inject 35 units subcutaneously daily, see drug leaflet. On June 11, 2024, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-A prepare R1's Lantus pen. ULP-A dialed the insulin pen to 35 units and expelled some insulin and then moved the dial to 35 units. ULP-A handed an alcohol pad to R1. ULP-A handed the insulin pen to R1. ULP-A looked away as R1 cleaned an area on her left abdomen and R1 self-injected the insulin. The surveyor did not observe specific instructions in R1's MAR regarding insulin injection site rotation or that R1 was to self-administer Lantus. On June 11, 2024, at 11:55 a.m., clinical nurse supervisor (CNS)-C stated the software used put in "see leaflet." CNS-C added the leaflet should be inside of the package with the insulin and the staff could look at the leaflet. On June 11, 2024, at 12:01 p.m., CNS-C stated R1's record contained no special instructions for insulin, adding insulin is given as instructed. On June 11, 2024, at 12:09 p.m., R1's MAR was reviewed with CNS-C. R1's MAR included one	01750		

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01750	Continued From page 32 line for insulin administration, for ULPs to document insulin as given by inserting ULP initials. CNS-C stated again, the software used added the "see leaflet" verbiage to each medication. The leaflet for Lantus was reviewed with CNS-C. CNS-C confirmed R1's record did not contain any instructions for documentation of injection sites used for Lantus administration. CNS-C confirmed R1's record did not include where insulin had been injected previously, for insulin site rotation. CNS-C stated the facility did not have a system in place for tracking insulin administration locations. In addition, CNS-C stated ULPs were to administer R1's insulin. The manufacturer's instructions for Lantus dated August 2022, noted it is important to rotate injection sites to avoid lipohypertrophy (pitted or thickened skin), or localized cutaneous amylidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened lumpy, tender, bruised, scaly, hard, scarred, or damaged. R2 R2's diagnoses include depression and hypertension (HTN/high blood pressure.) R2's service plan reviewed and updated May 7, 2024, indicated R2 received medication administration three times a day and PRN. R2's prescriber's orders dated April 12, 2024, included: -potassium chloride crystal (supplement) ER (extended release) 20 mEq (milliequivalents/measurement), take one tablet by mouth twice a day.	01750		

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01750	Continued From page 33 R2's MAR dated June 1, 2024, through June 10, 2024, included: -potassium chloride 20 mEq ER tablet, take one tablet by mouth twice a day, see drug leaflet. On June 11, 2024, at 9:33 a.m., the surveyor observed ULP-A unlock a cabinet in the downstairs office and removed R2's medication which included a bubble pack of medication. ULP-A took the medication to R2 who was sitting in a chair in the lower-level common's area. ULP-A removed potassium chloride medication from the bubble pack and cut the white pill in half. ULP-A administered R2's medication to R2. The surveyor did not observe specific instructions in R2's MAR to cut potassium chloride in half prior to administration. On June 12, 2024, at 10:29 a.m., CNS-C stated R2's record did not need instructions for potassium chloride adding " it's common sense." CNS-C said "you only put instructions in (the record) if he (R2) wanted it that way every day, but not occasionally. CNS-C stated some days R2 might take it (potassium chloride medication) whole. CNS-C said staff (ULPs) use their judgement. CNS-C confirmed R2's MAR did not contain any specific instructions for potassium chloride administration. The manufacturer's instructions for potassium Chloride ER dated June 4, 2024, noted inform patients to take each dose with meals and with a full glass of water or other liquid, and to not crush, chew, or suck the tablets. The licensee's Medication Administration policy dated August 1, 2021, noted the registered nurse may delegate medication administration to an unlicensed staff member according to the	01750		

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01750	Continued From page 34 following protocol: -the registered nurse had prepared written instructions for the home health aide (ULP) in the proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as directed for two of three residents (R1, R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 35 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: R1 R1's diagnoses include depression, diabetes, and PTSD (post-traumatic stress disorder/mental health disorder that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.) R1's service plan reviewed and updated June 1, 2024, included: -medication administration three times a day and as needed (PRN). R1's Individualized Medication Management Plan form reviewed and updated June 1, 2024, included: -medication reminders by staff -assistance with self-administration of medication (may include providing food/fluids) by facility staff -medication administration by facility staff. -documentation related to medications are located: on the medication administration record (MAR). R1's prescriber's orders dated September 27, 2023, included: -Lantus Solostar (long-acting insulin/diabetes) 100 units/milliliter (ml) inject 35 units	01760		

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01760	Continued From page 36 subcutaneously (under the skin/ fatty tissue). R1's medication administration record (MAR) dated June 1, 2024 through June 10, 2024, included: -Lantus Solostar 100/units ml subcutaneous solution pen injection, inject 35 units subcutaneously daily, see drug leaflet. R1's Master Care Plan reviewed and updated June 1, 2024, included: -staff assist with blood sugar check and insulin administration -client (resident) can administer insulin by himself, efficient with return demonstration has adequate knowledge with his sliding scale. On June 11, 2024, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-A prepare R1's Lantus pen. ULP-A dialed the insulin pen to 35 units and expelled some insulin and then moved the dial to 35 units. ULP-A handed an alcohol pad to R1. ULP-A handed the insulin pen to R1. ULP-A looked away as R1 cleaned an area on her left abdomen and self-injected the insulin. On June 11, 2024, at 12:04 p.m., clinical nurse supervisor (CNS)-C stated R1 was not to self-administer insulin, and that the ULP did it incorrectly. CNS-C confirmed R1's insulin was not given as directed. On June 12, 2024, at 9:28 a.m., the surveyor reviewed R1's Master Care plan reviewed and updated June 1, 2024, with CNS-C. CNS-C stated that (insulin/self-administration and sliding scale) assessment was not correct. R2 R2's diagnoses include depression and	01760		

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01760	Continued From page 37 hypertension (HTN/high blood pressure.) R2's service plan reviewed and updated May 7, 2024, indicated R2 received medication administration three times a day and PRN. R2's MAR dated June 1, 2024, through June 11, 2024, included: -pantoprazole (stomach acid) 40 milligrams (mg) tablet, take one tablet by mouth twice a day before a meal, see drug leaflet. On June 11, 2024, at 7:16 a.m., the surveyor observed ULP-A ask R2 what R2 would like for breakfast. ULP-A prepared a bowl of cereal and a cup of coffee for R2. R2 ate breakfast in the common's area on the upper level. On June 11, 2024, at 9:33 a.m., the surveyor observed ULP-A prepare and administer R2's morning medication, to include pantoprazole 40 mg. On June 12, 2024, at 10:24 a.m., R2's MAR was reviewed with CNS-C. CNS-C stated pantoprazole 40 mg should have been given before "he" (R2) ate. CNS-C confirmed R2's medication was not administered as directed. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, noted a registered nurse or licensed health professional at (name of AL (assisted living) may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional at (name of AL) delegated tasks to unlicensed personnel, that person would ensure that prior to	01760		

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01760	Continued From page 38 the delegation the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each resident and was able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication stored in a securely locked and substantially constructed compartment and only accessible by authorized personnel for three of three residents (R1, R2, R4). 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:	01880		

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01880	Continued From page 39 R1 R1's diagnoses include depression, diabetes, and PTSD (post-traumatic stress disorder/mental health disorder that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.) R1's service plan reviewed and updated June 1, 2024, included: -medication administration three times a day and as needed (PRN). R1's Individualized Medication Management Plan dated June 1, 2024, indicated: -medications are stored in a locked medication cart. On June 11, 2024, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-A unlock a cabinet in the downstairs office and remove a blood sugar (BS) machine, a needle (for BS machine), BS testing strips, Lantus 100 units/milliliters (ml) (long-acting insulin/ diabetes) pen, and bubble pack of medication out of a drawer. ULP-A took the supplies and placed them down onto a side table near R1. R1 was seated in an open common's area on the lower level, near the office door. ULP-A went to the office. The surveyor observed R1's bubble pack of medications and the Lantus pen unsecured. ULP-A returned with a lancet (device used to make a small incision into the skin). ULP-A used the lancet to obtain a droplet of blood from R1's finger. ULP-A received a BS reading of 171. ULP-A placed the BS machine back into a bag and put the lancet into a Sharps container (container used to collect needles/single use) positioned near R1. ULP-A prepared R1's insulin	01880		

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CURE HOME HEALTH INC	508 VAN BUREN AVENUE SAINT PAUL, MN 55103

(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
01880	Continued From page 40 and opened the bubble pack of medication and put the oral medication into R1's hand. R1 took the oral morning medication with water and injected the Lantus into her abdomen. The Lantus pen was placed on the side table. R1 returned to her room. ULP-A went to the bathroom on the lower level to perform hand hygiene. The surveyor observed the Lantus pen sitting on the side table near where R1 had been seated unsecured. On June 11, 2024, at 8:30 a.m., ULP-A took R1's Lantus pen and placed it into the locked cabinet in the downstairs' office. R2 R2's diagnoses include depression and hypertension (HTN/high blood pressure.) R2's service plan reviewed and updated May 7, 2024, indicated R2 received medication administration three times a day and PRN. R2's Medication Assessment for Safety in Self Administration form, dated May 7, 2024, indicated: R2: unable to demonstrate secure storage of medication kept in room R2: resident is deemed UNABLE to safely self-administer medication due to poor judgement and insight and history of none complaint (sic) (compliant.) On June 11, 2024, at 9:33 a.m., the surveyor observed ULP-A unlock a cabinet in the downstairs office and remove a bubble pack of medication and a bottle of lactulose (liver complications) for R2. ULP-A took the medication to R2 who was sitting in a chair in the lower-level common's area and administered R2's oral	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37458	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURE HOME HEALTH INC	508 VAN BUREN AVENUE SAINT PAUL, MN 55103

(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
01880	Continued From page 41 medication and poured lactulose into a medication cup and handed the cup to R2. ULP-A took the cup and rinsed it out in the lower-level bathroom. The surveyor observed the bottle of lactulose sitting on the side table in the lower-level common's area. On June 11, 2024, at 9:50 a.m., the surveyor asked ULP-A about R2's lactulose being left unsecured. ULP-A stated "I never do that, that is not who I am." On June 11, 2024, at 9:51 a.m., ULP-A was shown R2's unsecured lactulose. ULP-A stated, "that is really terrible, thank you so much" (for bringing the unsecured medication to ULP-A's attention). R4 R4's diagnoses include alcohol use disorder. R4's service plan reviewed and updated April 5, 2024, indicated R4 received medication administration two times per day. R4's Medication Assessment for Safety in Self Administration form, dated April 5, 2024, indicated: R4: unable to demonstrate secure storage of medication kept in room R4: resident is deemed UNABLE to safely self-administer medication due to poor judgement and insight and history of none complaint (sic) (compliant.) On June 11, 2024, at 9:45 a.m., the surveyor observed ULP-A unlock a gray filing cabinet located in the downstairs office and remove a bubble pack of medication dated June 11, 2024, from a multi pack of bubble packed medications	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37458	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURE HOME HEALTH INC	508 VAN BUREN AVENUE SAINT PAUL, MN 55103

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01880	Continued From page 42 for R4. ULP-A returned the multi pack of bubble packed medication to the gray filing cabinet drawer. The surveyor did not observe ULP-A lock the gray filing cabinet. ULP-A took the medication to the computer to compare the medication in the bubble pack to R4's medication record. The surveyor did not observe ULP-A close and lock the office door which had a sign posed: -Medication room: keep this door closed at all times. ULP-A took R4's medication upstairs and administered R4's medication. On June 11, 2024, at 10:59 a.m., clinical nurse supervisor (CNS)-C stated all supplies should be gathered at one time and medications should not be left unsecured. On June 11, 2024, at 11:00 a.m., CNS-C stated R2's lactulose should have been secured after R2's medication administration. On June 11, 2024, at 11:01 a.m., CNS-C observed the unlocked cabinet where R4's bubble packed medications were stored. CNS-C stated R4's medication needed to be locked up/secured. CNS-C confirmed medications were not secured as required. On June 11, 2024, at 11:04 a.m., ULP-A stated the key (to the gray filing cabinet) was giving him a hard time, "it is getting stuck, I don't know what is wrong with the key." ULP-A confirmed the cabinet that contained R4's medication was to be secured. CNS-C stated R4's medications would be moved to the other locked medication cabinet. The licensee's Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with each resident's medication	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37458	A. BUILDING: _____ B. WING _____	06/12/2024

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01880	Continued From page 43 management plan and service plan. Medication managed by the (name of facility) would be stored to prevent diversion of medication by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications for one of two residents (R1.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37458	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 44 On June 12, 2024, at 10:38 a.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the locked medication cabinet. CNS-C observed and confirmed the following: -R1's two opened Lantus 100 units/milliliters (ml) (long-acting insulin/diabetes) pens. The Lantus pens did not indicate when the pens were opened or when they would expire. Directly after the above observation CNS-C sated the insulin pens should have been dated for 28 days. CNS-C confirmed R1's two Lantus pens were not dated as required. The manufacturer's instructions for Lantus pens dated 2022, noted after 28 days throw your opened Lantus pen away, even if it still had insulin in it. The licensee's Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with each resident's medication management plan and service plan. Medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/11/24*
Time: 10:00:00
Report: 1039241169

Food and Beverage Establishment Inspection Report

Location:
Cure Home Health Inc
508 Van Buren Avenue
St Paul, MN55103
Ramsey County, 62

Establishment Info:
ID #: 0039245
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122321505
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.

MILK IN REFRIGERATOR MEASURES 46 DEGREES F. AMBIENT TEMPERATURE MEASURES 47 DEGREES F. PIC ADJUSTED THERMOSTAT SETTING AND CONFIRMED BY PHOTOGRAPH AMBIENT TEMPERATURE DEGREASED TO 40 DEGREES. CORRECTED 6/12/2025.

Comply By: 06/12/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP PRESENT AT KITCHEN SINK. STAFF HAVE BEEN USING ADJACENT BATHROOM SINK FOR HANDWASHING. DISCONTINUE AND ADD SOAP TO KITCHEN SINK.

Comply By: 06/12/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HANDWASHING SIGN REMINDER SIGN AT DESIGNATED HANDWASHING PART OF 2-COMPARTMENT SINK. PIC ADDED SIGN. CORRECTED ON SITE.

Corrected on Site

Type: Full
Date: *06/11/24*
Time: 10:00:00
Report: 1039241169
Cure Home Health Inc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Utensil Surface Temp: = at 175 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: AMBIENT
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Cyndi Casey.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate wood floor, painted walls with popcorn ceiling and faux-stone countertops. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Per irreversible waterproof thermometer, the dish washing machine achieves a utensil surface temperature of 175 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen. A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

Type: Full
Date: *06/11/24*
Time: 10:00:00
Report: 1039241169
Cure Home Health Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241169 of 06/11/24.

Certified Food Protection Manager: Ahmed M. Salah

Certification Number: FM114514 Expires: 12/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Zahra Yousuf
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us