Electronically Delivered

August 25, 2026

Licensee
Upend Home Health Care
1698 Beech Street
Saint Paul, MN 55106

RE: Project Number(s) SL35706016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 23, 2026, 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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:

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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.

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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

(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: SL35706016-0 On July 21, 2026, through July 23, 2026, 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 four residents; four receiving services under the Assisted Living Facility 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed cleaning and disinfection of medical equipment per manufacturer instructions for one of two employees (unlicensed personnel (ULP)-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: ULP-C was hired July 2, 2024, and provided direct care to residents.	0 510		

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0 510	Continued From page 2 On July 22, 2026, from 8:06 a.m. to 8:15 a.m., during continuous observation, the surveyor observed ULP-C assist R2 with blood glucose testing using R2's Assure Platinum blood glucose meter at the facility kitchen table. ULP-C placed a paper towel onto the kitchen table and blood glucose testing supplies were placed onto the paper towel. After completing the blood glucose test, without cleaning or disinfecting R2's blood glucose meter, the meter was placed back into an unlabeled plastic container and into the locked medication file cabinet. On July 22, 2026, at 8:26 a.m., ULP-C stated, the employees cleaned the blood glucose meter daily but there was no place they documented this cleaning. ULP-C verbalized he did not clean the blood glucose meter before or after he completed R2's blood glucose testing, while being observed. On July 22, 2026, at 8:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were trained to clean and disinfect the blood glucose meter after each use. LALD/CNS-A stated she completed infection control training with all employees upon hire and annually. The Centers for Disease Control and Prevention (CDC) guidance, Considerations for Blood Glucose Monitoring and Insulin Administration, dated August 7, 2024, indicated, "Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions." The manufacturer directions for Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System revised September 2024, indicated under Cleaning and Disinfecting FAQ: "If a blood glucose meter is assigned to an	0 510		

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0 510	Continued From page 3 individual resident and not shared, does it still need to be cleaned and disinfected? To ensure compliance ARKRAY recommends that blood glucose meters be cleaned and disinfected after each use. Each meter in use is subject to QC testing per the facility's policy." Also, included, "Can cleaning and disinfecting be accomplished with one wipe? No, each time the cleaning and disinfecting procedure is performed two wipes are needed. One wipe to clean the meter and a second wipe to disinfect the meter." The licensee's Infection Control policy, effective February 10, 2025, indicated, [Licensee] will observe the recommend precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA (Occupational Safety and Health Administration) regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control." The licensee's Equipment Safety policy, effective February 10, 2025, indicated, "1. When a resident is admitted to [Licensee], the RN notes any equipment used by him or her. The equipment supplier, if known, is documented in the clinical record. 2. The equipment is inspected by staff before use to assure that it is clean and in good working order. 3. The manufacturer's specifications and guidelines are followed for equipment operation and safety. 4. When cleaning equipment, unless otherwise specified, the following procedure is	0 510		

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0 510	Continued From page 4 used. a. Wash hands b. Put on gloves c. Apply germicidal spray liberally to the equipment d. Leave the germicidal spray on the equipment for 10 minutes e. Dry with a clean cloth." 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 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 and interview, the licensee failed to support protection and safety by not	0 550		

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0 550	Continued From page 5 posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors of the facility. 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: During a facility tour on July 21, 2026, at 10:50 a.m., the surveyor observed the facility postings and a grievance form located on a bulletin board in the main entrance of the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The grievance form lacked contact information including the name, email, and phone number for the contact person for the individual responsible for handling resident grievances. On July 21, 2026, at 11:05 a.m., LALD/CNS-A stated she was not aware of the required information to be posted on the grievance procedure to include the facility contact name, email address, and phone number. Education provided. The licensee's Grievance policy effective February 10, 2025, indicated, "2. A copy of the grievance procedure is conspicuously posted in	0 550		

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0 550	Continued From page 6 the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints -Contact information for the state and any regional Office of Ombudsman for Long-Term-Care -Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities -Contact information for the Minnesota Adult Abuse Reporting Center -Contact information for the Minnesota Department of Health, Office of Health Facility Complaints if an individual has a complaint about the facility or person providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 7 by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (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, 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: R2 R2 was admitted on April 1, 2021, and had diagnoses including schizophrenia. R2's signed Service Plan - Modification," effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. R4 R4 was admitted on May 9, 2026, and had diagnoses including chronic obstructive pulmonary disease (COPD), schizophrenia, depression, and epilepsy (a seizure disorder). R4's signed "Service Plan - Modification," effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care, safety checks, behavior	0 630		

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0 630	Continued From page 8 management, and medication administration. R2 and R4's records included IAPPs dated May 19, 2026, and May 26, 2026, respectively. Both documents lacked the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On July 22, 2026, at 9:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, she was not aware of all the required content for the IAPP and was not aware R2 and R4's IAPP was missing an assessment of the risk of abuse to other vulnerable adults and specific interventions for staff. LALD/CNS-A verbalized she planned to follow up with the licensee's electronic medical record provider to see if the additional vulnerability assessment questions could be added. LALD/CNS-A verified the licensee utilized the same IAPP assessment for all residents of the facility. The licensee's Vulnerable Adult policy effective February 10, 2025, indicated, "2. The assisted living employee has responsibility for the following: a. Assessment of vulnerability status of each resident upon admission. Susceptibility to abuse includes self abuse and neglect and risk of abuse by other individuals, including other vulnerable adults, in the following areas: 1) Physical 2) Verbal (emotional/psychosocial) 3) Sexual 4) Financial Exploitation 5) Self Abuse	0 630		

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0 630	Continued From page 9 b. The resident's risk of abusing other vulnerable adults within the residence shall be assessed. c. The vulnerable adult status assessment shall be documented in the clinical record. d. An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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 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.	0 650		

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0 650	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included the required content for two of two employees (unlicensed personnel (ULP)-C, registered nurse (RN)-D). 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: ULP-C and RN-D were hired by the licensee on July 2, 2024, and April 21, 2021, respectively, to provide direct care and services to residents. ULP-C and RN-D's employee record lacked evidence of an annual performance evaluation that identified areas of improvement needed and training needs. On July 22, 2026, at 10:30 a.m., owner/manager (O/M)-B stated, they did not know they were required to complete an annual performance review for all employees. The surveyor showed the licensee an example of an annual performance review tool the licensee had in their Forms Manual binder. O/M-B verbalized they had not completed performance reviews with their employees but will plan to start doing these with each employee.	0 650		

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0 650	Continued From page 11 The licensee's Performance Evaluation policy, effective February 10, 2025, indicated, "All paid employees, individual contractors and regularly scheduled volunteers providing assisted living services will participate in an annual performance evaluation. The purpose of the evaluation is to measure job performance and assist the employee and supervisor to build on the strengths of the employee and identify those areas needing improvement." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

(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 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 review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license. 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 undated EPP lacked the following required content: -maintain and annual EPP updates; -process for emergency preparedness collaboration; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for medical documents; -policies and procedures for arrangements with other facilities; -emergency officials contact information; -methods for sharing information;	0 680		

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0 680	Continued From page 13 -procedure for sharing information on occupancy and or needs; and -emergency prep testing requirements. On July 22, 2026, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner/manager (O/M)-B stated the licensee was not familiar with Appendix Z and the required content to be included in their EPP. O/M-B verbalized she was not aware of the required review of the missing resident policy and they were still working on updating their EPP to be compliant with state requirements. The licensee's Emergency Preparedness policy, effective February 10, 2025, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." The licensee's Missing Resident policy, effective February 10, 2025, indicated, "The missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented." Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements.	0 680		

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0 680	Continued From page 14 This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 15 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included accurate documentation that services had been provided as identified in the service plan for two of two residents (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, 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:	0 730		

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0 730	Continued From page 16 R2 R2 was admitted on April 1, 2021, and had diagnoses including schizophrenia. R2's signed Service Plan - Modification, effective July 14, 2026, indicated R2 received services including assistance with meals (three times daily), activities (three times daily), ambulation (three times daily), grooming (daily), managing behavior (anxiety-two times daily, "repetetive"-two times daily), safety checks (four times per day), blood glucose monitoring (daily), and medication administration (two times daily). R2's record included a Master Care Plan, dated May 19, 2026, indicating on page five, section titled "Safety, Elopement Risk; Resident is at risk of elopement / wandering, specify actions required: - Note: Client needs monitor 24 to prevent elopement." R2's Service Recap Summary - Month dated July 1, 2026, to July 21, 2026, lacked documentation the following services were provided, or the reason a service was not provided: -July 1, 7-9, 13-16, "Safety Check 12:00 AM"; and -July 1-16, 18-21, "Safety Check 06:00 PM". R4 R4 was admitted on May 9, 2026, and had diagnoses including chronic obstructive pulmonary disease (COPD), schizophrenia, depression, and epilepsy (a seizure disorder). R4's signed "Service Plan - Modification, effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care (three times per day), safety checks (three times per day), behavior management-anxiety	0 730		

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0 730	Continued From page 17 (three times per day), behavior management-physical aggression (three times a day), behavior management-self-injurious (three times a day), behavior management-verbal aggression (three times a day), and medication administration (five times per day). R4's Service Recap Summary - Month dated July 1, 2026, to July 21, 2026, lacked documentation the following services were provided, or the reason a service was not provided: -July 1-21, "Equipment Care - Respiratory AM"; -July 1-16, 19-21, "Equipment Care - Respiratory PM"; -July 1-2, 5-8, 12-15, 18-21, "Equipment Care - Respiratory Overnight"; -July 1-21, "Safety Check AM"; -July 1-16, 19-21, "Safety Check PM"; and -July 1, 6-8, 12-15, 21, "Safety Check Overnight." On July 22, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware there was missing documentation for some services provided for both R2 and R4, and LALD/CNS-A planned to do more education on the importance of service documentation with all employees. The licensee's Clinical Records policy, effective February 10, 2025, included "6. The clinical record contains the following information: -Resident's name -Address -Telephone number -Date of birth -Admission/discharge dates -Names, addresses and telephone numbers of an emergency contact and family members or responsible parties -Names, addresses and telephone numbers of	0 730		

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0 730	Continued From page 18 the resident's legal representatives and designated representatives -Pertinent health information -Medical history -Allergies -Advance directives, if any -Copies of health care directives, guardianships, powers of attorney or conservatorships -Current and previous Service Plans -Current and previous nursing assessments -Medications, treatment and/or therapies, if pertinent -Documentation of communication/coordination pertinent to the resident's assisted living services -Documentation of incidents and/or significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health professional -Documentation of services provided as identified in the service plan -Documentation** that the resident has received and reviewed the following -Assisted Living Bill of Rights -Scope of Services policy -Grievances and resolution, as applicable -Discharge summary and related documentation, including service termination notice, when applicable -Names, addresses and telephone numbers of the resident's health and medical services providers and other home health agencies, if known -Other information needed to provide assisted living service." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 810 SS=I	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) staff 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) Staff 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 staff 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	0 810		

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0 810	Continued From page 20 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	0 910		

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0 910	Continued From page 21 (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 ensure the assisted living contract included all required content for two of two residents (R2, R4). This practice resulted in a level one violation (a violation that will cause only 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: R2 R2's signed Service Plan - Modification," effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. R2's Resident Agreement (contract) signed April 1, 2021, lacked the following: -the health facility identification (HFID) number of the facility. R4 R4's signed "Service Plan - Modification, effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care, safety checks, behavior management, and medication administration. R4's Resident Agreement signed May 9, 2026,	0 910		

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0 910	Continued From page 22 lacked the following: -HFID number of the facility. On July 21, 2026, at 12:17 p.m., owner/manager (O/M)-B stated she was not aware the assisted living contract was missing the required content as identified above. O/M-B verbalized she did not realize the licensee shared with the surveyor two different contracts and she planned to follow up on the missing required content with the consultant provider the licensee used. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060		

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01060	Continued From page 23 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content after an emergency relocation, for one of two residents (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, 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).	01060		

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01060	Continued From page 24 The findings include: R4 was admitted on May 9, 2026, and had diagnoses including chronic obstructive pulmonary disease (COPD), schizophrenia, depression, and epilepsy (a seizure disorder). R4's signed "Service Plan - Modification, effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care, safety checks, behavior management, and medication administration. On July 21, 2026, at 10:05 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R4 had recently been admitted to the hospital with pneumonia. R4's Resident Notes dated June 28, 2026, at 8:54 p.m., indicated R4 was admitted to the hospital. The note included, "The patient was hospitalized after developing wheezing, shortness of breath, and decreased respiratory status. The patient was evaluated in the emergency department and diagnosed with pneumonia. Oxygen therapy and appropriate medical treatment were initiated. The patient's respiratory status continues to be monitored closely. The attending physician was notified, and the patient remains hospitalized for further evaluation and treatment. Ongoing monitoring of oxygen saturation, respiratory status, vital signs, and response to treatment is in progress." R4's record included a clinical update assessment dated June 30, 2026, completed by LALD/CNS-A after R4 was discharged back to the facility from the hospitalization, two days after being admitted.	01060		

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01060	Continued From page 25 R4's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative at the time of the hospitalization that contained at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On July 22, 2026, at 10:52 a.m., LALD/CNS-A and owner/manager (O/M)-B stated they were not aware of the requirement to provide an emergency relocation notice for residents who were admitted to the hospital, or to notify the OOLTC if a resident remained in the hospital for more than four days. LALD/CNS-A stated an emergency relocation notice, and notifications were not completed for R4's hospitalization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

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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
01530	Continued From page 26 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed two hours of initial training on mental illness and de-escalation within 160 hours of start date and one hour of annual training on mental illness and de-escalation topics for two of two employees (unlicensed personnel (ULP)-C, registered nurse (RN)-D). 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: ULP-C ULP-C was hired July 2, 2024, and provided direct care services for the residents. On July 22, 2026, from 8:06 a.m. to 8:25 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-C assist R2 with blood glucose testing and medication administration. RN-D RN-D was hired April 21, 2021, and provided direct nursing care services for the licensee's	01530		

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01530	Continued From page 28 assisted living residents as of August 1, 2021. ULP-C and RN-D's employee records lacked documentation they completed the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date and one hour of annual training on mental illness and de-escalation topics as required, effective July 1, 2025. On July 21, 2026, at approximately 12:00 p.m., ULP-C stated he did not recall taking any mental health and de-escalation training since he started employment. On July 21, 2026, at 12:57 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner/manager (O/M)-B stated they could not find a way to show the hours of mental illness and de-escalation training for ULP-C and RN-D. O/M-B verbalized the licensee used a training manual provided by a consultant company, and the licensee would have the employees read the training manual to complete their training. O/M-B stated she was not sure how she could show the amount of time spent on each of the trainings but planned to follow up to get this corrected. The licensee's Education on Mental Illness and De-escalation policy, effective, February 10, 2025, indicated, "3. Direct care employees must have completed at least two (2) hours of initial education** within 160 working hours of the employment start date in the following topics: a. Recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma-and stressor-related disorders, personality and psychotic disorders, substance use	01530		

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01530	Continued From page 29 disorder, and substance misuse; b. De-escalation techniques and communication; and c. Crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	01620		

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01620	Continued From page 30 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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 calendar days from the date of the last review. (f) 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 a registered nurse (RN) conducted resident monitoring and reassessment including ongoing reassessments not to exceed 90 days from the previous assessment, for one of two residents (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	01620		

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01620	Continued From page 31 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: R2's signed Service Plan - Modification, effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. On July 22, 2026, from 8:06 a.m. to 8:25 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-C assist R2 with blood glucose testing and medication administration. R2's medical record included a nursing reassessment, dated February 5, 2026, and a subsequent reassessment dated May 19, 2026, greater than 90 days (103 days) after the previous assessment. On July 22, 2026, at 9:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2's assessment must have been completed late. LALD/CNS-A verbalized she puts the resident assessments on a calendar, but she must have missed completing it on time. The licensee's Assessment and Reassessment policy, effective February 10, 2025, indicated, "8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment."	01620		

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01620	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 33 Based on observation, interview, and record review, the licensee failed to ensure the resident service plan included the required content for two of two residents (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, 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: R2 R2 was admitted on April 1, 2021, and had diagnoses including schizophrenia. R2's signed "Service Plan - Modification," effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. On July 22, 2026, from 8:06 a.m. to 8:25 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-C assist R2 with blood glucose testing and medication administration. R4 R4 was admitted on May 9, 2026, and had diagnoses including chronic obstructive pulmonary disease (COPD), schizophrenia, depression, and epilepsy (a seizure disorder).	01650		

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01650	Continued From page 34 R4's signed "Service Plan - Modification," effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care, safety checks, behavior management, and medication administration. On July 21, 2026, at 10:30 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A providing a verbal cues reminding R4 to be mindful of his oxygen tubing which extended from his oxygen concentrator located in his bedroom to the main living area of the facility. R2 and R4's service plans both lacked the following: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 22, 2026, at 9:00 a.m., LALD/CNS-A stated the licensee used an electronic medical	01650		

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01650	Continued From page 35 record document report titled Service Plan - Modification for the resident service plans. LALD/CNS-A verbalized she was not aware the licensee's service plan did not include all the required content. LALD/CNS-A stated the licensee would ensure the residents received a service plan with all the required content. The licensee's Service Plan policy effective February 10, 2025, indicated, "8. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff providing services** f. A contingency plan that includes the following i. Action to be taken if the scheduled service could not be provided ii. Information and method for a resident or resident's representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives."	01650		

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01650	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=D	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 delegated procedures were followed during medication administration for one of two residents (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 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).	01750		

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01750	Continued From page 37 The findings include: R2 was admitted on April 1, 2021, and had diagnoses including schizophrenia. R2's signed "Service Plan - Modification," effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. R2's paper medication administration record (MAR) dated July 2026, indicated staff assisted R2 with administration of the following: -rosuvastatin (for high cholesterol) 10 milligrams (mg), one tablet daily; -vitamin D (a supplement) 50 micrograms (mcg), one tablet daily; -risperidone (an antipsychotic) 1 mg, one tablet daily at bedtime; -risperidone 4 mg, one tablet every night at bedtime with 1 mg for a total dose 5 mg; and -Glucophage (to control high blood sugar levels) extended release (XR) 500 mg, one tablet every evening with food." On July 22, 2026, from 8:15 a.m. to 8:25 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. ULP-C opened the locked medication file cabinet and obtained a pharmacy filled pill pack with R2's morning medications. ULP-C pointed at the two medications printed on the MAR, removed the two medications from the pill pack and placed them into a medication cup. Without comparing the medication to the MAR, and performing the appropriate "rights" of medication administration to ensure accuracy, ULP-C handed R2 the	01750		

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01750	Continued From page 38 medications and observed R2 take the medications. On July 22, 2026, at 8:26 a.m., ULP-C stated he was trained by the nurse on medication administration and verbalized he should have checked the MAR before he administered R2's medications. ULP-C stated he was nervous due to being observed by the surveyor and missed this important step of medication administration. On July 22, 2026, at 8:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C should have checked the MAR before administering R2's medications, per the training she had provided. The licensee's Medication Administration policy effective February 10, 2025, indicated, "Residents of [Licensee] are entitled to the safe administration of medications by qualified personnel according to a written Medication Management Plan." Also, included, "6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment and therapy management record with all required content for two of two	01940		

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UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

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01940	Continued From page 40 residents (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, 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: R2 R2 was admitted on April 1, 2021, and had diagnoses including schizophrenia. R2's signed "Service Plan - Modification," effective July 14, 2026, indicated R2 received services including assistance with meals, activities, ambulation. grooming, managing behavior, safety checks, blood glucose monitoring, and medication administration. On July 22, 2026, from 8:06 a.m. to 8:25 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-C assist R2 with blood glucose testing and medication administration. R2's signed provider orders dated December 31, 2025, indicated R2 was to receive assistance with blood glucose monitoring every other day. R2's paper medication administration record (MAR) dated July 2026, indicated R2 received assistance with the following treatments: -blood glucose testing every other day in the morning.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

(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
01940	Continued From page 41 R2's medical record lacked an accurate individualized treatment and therapy plan that included: -documentation of specific resident instructions related to the treatment or therapy administration, and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. R4 R4 was admitted on May 9, 2026, and had diagnoses including chronic obstructive pulmonary disease (COPD), schizophrenia, depression, and epilepsy (a seizure disorder). R4's signed "Service Plan - Modification, effective July 14, 2026, indicated R4 received services including assistance with respiratory equipment care, safety checks, behavior management, and medication administration. R4's assessment dated June 30, 2026, included an activities of daily living (ADL) category titled Respiratory Equipment and indicated R2 needed assistance with oxygen, and staff to assist client with oxygen. R4's signed provider orders dated May 13, 2026, indicated R4 was to be administered oxygen two liters (2L) via nasal cannula (used to deliver oxygen into the nose). R4's Service Recap Summary - Month, dated July 2026, indicated R4 received assistance with the following treatments: -"Equipment Care - Respiratory," morning (AM), evening (PM), and overnight.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

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01940	Continued From page 42 On July 21, 2026, at 10:50 a.m., the surveyor observed R4's bedroom with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and R4. R4 stated he always used his oxygen at all times day and night. R4's oxygen concentrator was located near his bed and set at 2L, with a nasal cannula attached. R4's medical record lacked an accurate individualized treatment and therapy plan that included: -an accurate statement of the type of services that will be provided; -documentation of specific resident instructions related to the treatment or therapy administration, and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On July 22, 2026, at 9:20 a.m., LALD/CNS-A stated she was not aware R2 and R4 did not have a completed treatment management plan with all the required content. LALD/CNS-A verbalized there were not clear instructions with how the employees should assist R2 with his blood glucose testing, or when to notify the nurse. Also, LALD/CNS-A stated she planned to get a treatment management plan with specific instructions on oxygen administration so the employees were able to meet R4's respiratory equipment needs. The licensee's Treatment and Therapy Management policy, effective, February 10, 2025, indicated, "6. The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPEND HOME HEALTH CARE	1698 BEECH STREET SAINT PAUL, MN 55106

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01940	Continued From page 43 ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Upend Home Health Care
1698 Beech Street
St Paul, MN 55106
Ramsey County
Parcel:

Phone:

License Info

License: HFID 35706

Risk:
License:
Expires on:
CFPM: ASAD MOHAMED
CFPM #: 63381; Exp: 7/24/2027

Inspection Info

Report Number: F8058261163
Inspection Type: Full - Single
Date: 7/22/2026 Time: 3:30:50 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR DEDE HINNENDAEL

ASAD MOHAMED PIC

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES WOOD CABINETS, LAMINATE FLOOR AND COUNTER, SOME FRP ON WINDOW WALL AND CEILING

37 TOMATO COOLER
38 APPLE COOLER
160 DISH MACHINE

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8058261163 from 7/22/2026

ASAD MOHAMED
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35706016-0	**Date:** July 22, 2026
Facility Name: Upend Home Health Care	
Facility Address: 1698 Beech St, St Paul, MN 55106	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP 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 provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Unlicensed personnel (ULP)-C provided documentation of what they claimed was staff training on the FSEP. The document contained a heading of Date Emergency Preparedness Program/Policies Established. The document provided by ULP-C did not mention staff training on FSEP. No staff training documentation on the FSEP was provided during survey.

4. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: ULP-C was unable to locate any resident training records on the FSEP.