Electronically Delivered

July 24, 2025

Licensee
Uplifted Care Services LLC
7724 Abbott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL33877016

Dear Licensee:

On July 9, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 15, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

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May 9, 2025

Licensee
Uplifted Care Services LLC
7724 Abbott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL33877016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

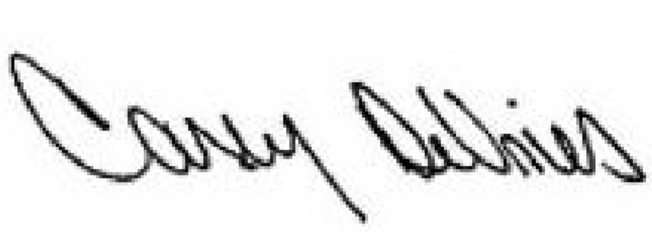
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33877	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFTED CARE SERVICES LLC	7724 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL33877016-0 On April 14, 2025, through April 15, 2025, 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, all of them received services under the Assisted Living license. An immediate correction order was identified on April 14, 2025, issued for SL33877016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for 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, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year to determine staffing levels to meet the needs of all residents.	0 470		

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0 470	Continued From page 2 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 held an assisted living facility license. The facility was licensed for a bed capacity of five residents and had a current census of four residents. On April 14, 2025, at approximately 2:20 p.m., clinical nurse supervisor (CNS)-C provided the surveyor with undated staffing plan. On April 14, 2024, at 2:20 p.m., CNS-C stated they reviewed the staffing plan once a year and they did not have documentation for when it was reviewed last. The licensee's undated 4.06 Staffing & Scheduling policy indicated the clinical nurse supervisor, would develop, write, and implement a staffing plan that would provide sufficient staff to meet the residents needs 24-hours a day, seven-days a week. The policy did not indicate how often the plan was supposed to be reviewed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 April 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance date.	0 480		
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E).	0 650		

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0 650	Continued From page 6 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: ULP-A ULP- A was hired on February 9, 2021, to provide direct cares and services to residents. On April 14, 2025, at 9:56a.m., the surveyor observed ULP-A administer oral medications to R1. ULP-A's employee record lacked the following: - annual performance review (last completed on February 9, 2022). ULP-B ULP- B was hired on September 20, 2021, to provide direct cares and services to residents. ULP-B's employee record lacked the following: - annual performance review (last completed on September 19, 2023). ULP-E ULP- E was hired on March 19, 2019, to provide direct cares and services to residents. ULP-E's employee record lacked the following: - annual performance review (last completed on March 30, 2022). On April 15, 2025, at 10:30 a.m., clinical nurse	0 650		

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0 650	Continued From page 7 supervisor (CNS)-C stated they did not remember why performance evaluations was not done in year 2023, and 2024. CNS-C stated they decide to do the performance evaluations for all employees in April. CNS-C stated they had not completed a performance evaluation for any employee, but they were working on getting it done for all employees by the end of April. The licensee's 4.35 Employee Records policy dated August 1, 2021, indicated all staff of the licensee will be given an employee evaluation at least annually. The evaluation form is to be signed by the supervisor and the employee. The original signed form is placed in in the employee's personnel file and a copy of the completed and signed form will be given to the employee. 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	0 660		

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0 660	Continued From page 8 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 14, 2025, at approximately 2:25 p.m., clinical nurse supervisor (CNS)-C provided the surveyor with a facility TB risk assessment completed on March 22, 2023, and indicated the facility was at a low risk for TB transmission. The TB risk assessment indicated the licensee would conduct or update the TB risk assessment annually. The licensee lacked an updated TB risk assessment which was due March 2024, and March 2025. On April 14, 2024, at 2:27 p.m., CNS-C stated they usually completed the TB risk assessment	0 660		

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0 660	Continued From page 9 every March and stated they could not find the one they completed March 2024. CNS-C stated they did not complete the TB risk assessment in March 2025 as they were focusing on fixing deficiencies they received following a survey conducted at the licensee's sister facility. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH dated June 2024, indicated facilities should perform a facility risk assessment on an annual basis. The licensee's Facility Tuberculosis (TB) Risk Assessment completed on March 22, 2023, indicated the facility will complete the Community TB Risk Assessments annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 10 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. This deficient condition had the ability to affect all staff 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 15, 2025, at approximately 12:30 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. During the tour, the surveyor observed the smoke alarms tested for interconnection by the licensee. Upon testing, it was found that the smoke alarms throughout the facility were not interconnected, and all smoke alarms only sounded locally when tested.	0 780		

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0 780	Continued From page 11 All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. On April 15, 2025, ULP-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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) 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.	0 810		

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0 810	Continued From page 12 (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 review, the licensee failed to provide the required drills per shift. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 15, 2025, unlicensed personnel (ULP)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted only during the "day" shift and no drills were performed during the "evening" shift. No other	0 810		

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0 810	Continued From page 13 documentation was provided. On April 15, 2025, ULP-A confirmed the facility has only performed evacuation drills with the day shift staff. ULP-A stated they will start drills with the evening shift staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 14 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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 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 two of three employees (unlicensed personnel (ULP)-A, ULP-E) received all the required contents of annual training. 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	01500		

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01500	Continued From page 15 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-A ULP- A was hired on February 9, 2021, to provide direct cares and services to residents. On April 14, 2025, at 9:56a.m., the surveyor observed ULP-A administer oral medications to R1. ULP-A's employee records included an Annual Training Tracking Form dated March 9, 2022, which indicated ULP-A had completed the following required annual training topics on February 5, 2022: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Infection control techniques; and - Principles of person-centered planning/service delivery. ULP-A's Educare (online training software) transcript indicated ULP-A completed the following required annual training topics: - Assisted Living Bill of Rights (completed on March 30, 2025); and - Infection control techniques (January 27, 2025). ULP-A's employee record lacked the following required annual training contents completed for each 12 months of ULP-A's employment: - Effective approaches to use to problems solve when working with a resident's challenging	01500		

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01500	Continued From page 16 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders (never completed); - Review of provider's policies and procedures (never completed); - Principles of person-centered planning/service delivery (completed on February 5, 2022); and -Reporting maltreatment of vulnerable adults or minors (completed on February 5, 2022). ULP-E ULP-E was hired on March 19, 2019, to provide direct cares and services to residents. ULP-E's Educare transcript indicated ULP-E completed the following required annual training topics: - Assisted Living Bill of Rights (completed on March 10, 2023); - Infection control techniques (completed on January 2, 2024); - Principles of person-centered planning/service delivery (completed on January 1, 2025); -Reporting maltreatment of vulnerable adults or minors (completed on March 17, 2025); and -Review of provider's policies and procedures (completed on March 15, 2025). ULP-E's employee record lacked the following required annual training contents completed for each 12 months of ULP-E's employment: - Assisted Living Bill of Rights (completed on March 10, 2023); and - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders (never completed). On April 15, 2025, at 10:13 a.m., clinical nurse	01500		

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01500	Continued From page 17 supervisor (CNS)-C stated the above-mentioned trainings were assigned to the ULPs but the ULPs did not complete the training. CNS-C stated in the past, when ULPs did not complete their training, they took the ULPs off the schedule until they complete their training, but they did not do that for the above-mentioned employees. On April 15, 2025, at 10:22 a.m., CNS-C stated they were not aware review of provider's policies and procedures and effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders were required to be included in the annual training contents previously. CNS-C stated they were made aware of the requirement following a recent survey conducted at the licensee's sister facility and now they have added the missing topics to the contents of annual training for all employees. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff providing assisted living services would complete at least eight hours of education for each 12 months of employment and the education topics would include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 18 disease or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedure 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=D	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 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	01620		

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01620	Continued From page 19 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 complete a change of condition reassessment when a resident presented with new or changed symptoms for one of one resident (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) 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 was admitted to the licensee on November 30, 2018, with diagnoses including shingles, schizophrenia, schizoaffective, bipolar, major depressive disorder, and anxiety disorder. R1's undated Service Plan indicated R1 received services for bathing, dressing, grooming, continence care, medication administration, and meal prep & home making. R1's record included an after-visit summary dated August 21, 2024, with instructions for after adult closed reduction nasal fracture open reduction internal fixation/ septoplasty/ rhinoplasty following R1's surgical procedure of the nose. R1's record contained nursing assessments completed on August 13, 2024, November 10,	01620		

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01620	Continued From page 20 2024, and February 5, 2025. R1's record lacked a change of condition assessment for R1's hospital return on August 21, 2024. The assessment completed on August 13, 2024, contained no mention of post operative care for R1's same day surgical procedure completed on August 21, 2024. On April 14, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-C stated the change of condition assessment was done on August 13, 2024, before the surgery. CNS-C further stated since the surgery was within 10 days of the assessment completed on August 13, 2024, they were able to edit the assessment, however CNS-C was unable to provide evidence of an edit made to the assessment on August 13, 2024. CNS-C stated, "I updated the medication list after surgery that is my evidence". The licensee 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 21 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 ensure time sensitive medications were labeled with the date opened for one of five 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 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 was admitted to the licensee on June 21, 2021, with diagnosis including diabetes mellitus, and schizoaffective disorder, depressive type. R2's Service Plan dated July 28, 2024, indicated R2 received services for dressing, bathing, meal preparation, home making, grooming, and medication administration. On April 15, 2025, at 1:37 p.m., the surveyor observed the medication cabinet and observed the following time sensitive medication was opened without an opened-on date label: - R2's Lantus Solostar 100unit/ML pen.	01890		

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01890	Continued From page 22 On April 15, 2025, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated they were not aware they needed to put an opened-on date on insulin pens. CNS-C further stated the pharmacy usually labeled insulin pens with residents' information, but they did not do it this time. The manufacturer's instructions for the use of Lantus Solostar (insulin glargine) injection last revised August 2022, directed the insulin glargine to be discarded after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee included language within a posting on a bulletin board located in common area in the living room which limited the rights of all residents residing within 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) and was issued at a	02290		

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02290	Continued From page 23 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 April 14, 2025, at approximately 12:05 p.m., the surveyor observed a House Rule posting on a bulletin board located in common area in the living room, on the main floor. The posting contained the following: " 1. This Facility is a no drug use facility. No Drugs or Alcohol allowed in the premises. Staff will search all resident personal belongings if there is reasonable suspicion of presence of any type of drugs or alcohol. 2. No physical aggression, assault or violence is allowed at this facility. Physical violence is grounds for dismissal or discharge from the facility. 3. No stealing other client's or facility valuables allowed. Stealing is grounds for dismissal or discharge from facility. 4. No one is allowed to keep cigarettes in his/her room. Cigarettes will be kept in the medication cart and dispensed by staff at time of need. No loose tobacco accepted as a form of cigarette. 5. No one is allowed to smoke inside the home. The whole body should be outside and door completely closed before a cigarette is lit. Door should be closed while actively smoking. 6. Borrowing of money or other valuable resources like cigarettes between consumers is completely prohibited. This includes cigarettes and everything else each client owns as personal property. 7. No food items or drinks allowed in the bedrooms. All food and snacks should be eaten in the dining room and leftovers clearly labeled	02290		

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02290	Continued From page 24 and put in the fridge. 8. Clients who are allowed to leave the home unsupervised as per individual care plans MUST sign themselves out and notify staff of their plans including places they will be visiting or going to, time of departure and estimated time of return. Please notify staff at least 24 hrs in advance to facilitate adequate planning especially medication set-up. It is each client's responsibility to request for the medications they will need to take with and sign for them. Clients must leave a phone number where they can be reached at all times. 9. Curfew time is 10pm. Clients who leave the home must be back by curfew time on the same day unless prior plans have been made to spend a night away from the home. Clients cannot spend more than one night consecutively away from home without prior plan and, during the leave of absence, making deliberate efforts to contact staff with information of their whereabouts. 10. FACILITY PHONE USAGE: The phone available at the premises is a business line that is used for official company business purposes that includes receiving calls from physicians, pharmacy and other professionals. Clients are allowed to use it without monopolizing it. All clients' calls are limited to blocks of 15 minutes per hour. No phone calls should be made after 9pm and before 8am unless there is an emergency. 11. 8 pm is quiet time during winter and 12 pm during summer. Staff will turn Common areas TV off at 8 pm. All clients are to respect other clients' right to adequate rest without interruption. No client is allowed to make noise close to other clients' bedrooms. 12. No client is allowed to enter another client's room without that client's express permission and presence in the room.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33877	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFTED CARE SERVICES LLC	7724 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443

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02290	Continued From page 25 13. Outings: There will be 2 outings per week for everyone who would like to participate. The management staff will schedule them. Any extra outings will need prior approval by the management team." On April 15, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-C stated the intention of the house rule was not to restrict residents; it was to keep them safe. CNS-C stated they had it on their schedule to reword the house rules to reflect encouragement rather than mandate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with hospital bed rails. This resulted in an immediate correction order on April 14, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310		

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02310	Continued From page 26 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on November 30, 2018, with diagnoses that included shingles, schizophrenia, schizoaffective, bipolar, major depressive disorder, and anxiety disorder. R1's undated Service Plan indicated R1 received services for bathing, dressing, grooming, continence care, medication administration, and meal preparation, and home making. On April 14, 2025, at approximately 11:45 a.m., the surveyor observed a hospital style bed with upper and lower bed rails on both sides of R1's bed. R1's record lacked assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition to include: - assessment of the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls; - assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance; - assessment of the resident to consider whether the bed rail has the effect of being an improper	02310		

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02310	Continued From page 27 restraint; - bed rail measurements and assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations; and - documentation that the risk virus benefit of using the bed rail was discussed with the resident. On April 14, 2025, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-C stated R1 started using the hospital bed following a nose surgery that required R1 to be on 30-degree angle while in bed. CNS-C stated R1 was not currently using the bed rail. CNS-C stated they tried to remove the bed rail, but they were unable to remove it as they could not figure out how to remove it. On April 14, 2025, at approximately 11:45 a.m., R1 stated they were not currently using the bed rail. On April 14, 2025, at 12:23 p.m., unlicensed personnel (ULP)-A stated R1 used the bed rail when R1 came back from the hospital. The surveyor asked how the bed rail was utilized. ULP-A stated there was a button to push to bring the bed rail up and down. CNS-C interjected and stated ULP-A was talking about putting the head of the bed up and down. The surveyor and ULP-A entered R1's room and ULP-A demonstrated how they had used the bed rail. ULP-A raised the lower half of the bed rail on the left side of the bed. ULP-A further stated R1 still used the bed rail on occasion. On April 14, 2025, at 12:44 p.m., CNS-C stated got the hospital bed before the surgery on August 21, 2024.	02310		

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02310	Continued From page 28 On April 14, 2025, at 12:46 p.m., CNS-C stated they did not do a bed rail assessment, they just followed doctor's orders that said R1 needed a bed that could raise up to a 30-degree angle, and the doctor did not mention the use of a bed rail. CNS-C stated they did not think the bed rail was necessary as R1 was able to get in and out of bed independently. CNS-C also stated they did not call the medical supply company to help them remove the bed rail when they determined R1 did not require it's use. CNS-C stated they had not added any instruction to R1's service plan, assessment, treatment plan, or anywhere to instruct the ULPs to not use the bed rails. CNS-C stated they were not aware R1 was sometimes using the bed rail. The licensee's staffing schedule for April 2025, indicated ULP-B worked night shifts from 7:00 p.m., to 7:00 a.m., and ULP-B had worked the night shift on April 13, 2025. On April 14, 2025, at 2:46 p.m., ULP-B stated R1 started using the bed rail after a hospital visit months ago. ULP-B stated they guessed R1 used the bed rail to prevent them from falling. ULP-B stated they raised the upper half of the bed rail up when R1 was in bed. ULP-B further stated R1 does not like the lower half of the bed rail raised up as R1 liked to go the bathroom at night freely. The surveyor inquired if R1 was still using the bedrail. ULP-B stated R1 had a procedure done recently, they thought an endoscopy, and they did still advise R1 to use the bed rail to prevent them from falling. On April 14, 2025, at 3:00 p.m., CNS-C stated R1 had colonoscopy done on April 9, 2025, not an endoscopy.	02310		

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02310	Continued From page 29 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." Additionally, the FAQ indicated documentation of a bed rail should include but is not limited to: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's 6.28 Side rails Policy indicated when the licensee is aware a home care resident is utilizing side rails (a medical device) on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying	02310		

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02310	Continued From page 30 the side rail. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *04/15/25*
Time: 11:30:00
Report: 1043251103

Food and Beverage Establishment Inspection Report

Location:
Uplifted Care Services Llc
7724 Abbott Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038117
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632803236
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED OVER READY-TO-EAT FOODS (VEGETABLES) IN FRIDGE. ADVISED STAFF TO STORE RAW FOOD AT BOTTOM. COMPLY WITH ABOVE RULE.

Comply By: 04/15/25

3-500A Microbial Control: cooling

3-501.14A ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

COOKED RICE IN FRIDGE MEASURED 82F. PER STAFF, RICE WAS MADE AT 8:00 AM AND TRANSFERRED TO FRIDGE BY 11:30 AM. ADVISED STAFF TO DISCARD RICE. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 04/15/25

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UNABLE TO CONFIRM. FACILITY HAS A DISH MACHINE WITH SANITIZING OPTION.

PERSON IN CHARGE DID NOT PROVIDE RESULTS UPON REQUEST BETWEEN 4/15-4/17. ADVISED STAFF TO TEST AND PROVIDE RESULTS TO SANITARIAN. COMPLY WITH ABOVE

Comply By: 04/15/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

FACILITY USES CHLORINE. TEST KIT EXPIRED IN 2023. ADVISED STAFF TO REPURCHASE AND MAINTAIN. COMPLY WITH ABOVE RULE.

Comply By: 04/15/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

SANI BUCKET MEASURED 0 PPM FOR CHLORINE. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 50-100 PPM. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 04/15/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LAMINATE KITCHEN COUNTERTOP OBSERVED TO BE WARPED IN MULTIPLE AREAS. ADVISED STAFF TO REPAIR AND MAINTAIN. PER STAFF, REPAIRS ARE SCHEDULED. COMPLY WITH ABOVE RULE.

Comply By: 04/15/25

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: Yes

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SANI BUCKET*
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Type: Full
Date: *04/15/25*
Time: 11:30:00
Report: 1043251103
Uplifted Care Services Llc

Food and Beverage Establishment Inspection Report

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

Inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, same day service, and food handling procedures.

This facility has a residential kitchen with laminate flooring, laminate counters, wooden cabinetry, and popcorn ceiling. Sanitizing option on dish machine must always be used when running a cycle.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043251103 of 04/15/25.

Certified Food Protection Manager: William Akuma

Certification Number: FM10444 Expires: 10/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
William Akuma
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us