Electronically Delivered

November 18, 2025

Licensee
Uplift Home Care Services LLC
14755 91st Place North
Maple Grove, MN 55369

RE: Project Number(s) SL39265016

Dear Licensee:

On October 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 26, 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,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

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Electronically Delivered

September 15, 2025

Licensee
Uplift Home Care Services LLC
14755 91st Place North
Maple Grove, MN 55369

RE: Project Number(s) SL39265016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 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;
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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 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 $2,500.00**. 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39265	A. BUILDING: _____ B. WING _____	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFT HOME CARE SERVICES LLC	14755 91ST PLACE NORTH MAPLE GROVE, MN 55369

(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 An immediate correction order was identified on July 29, 2025, issued for SL39265016-0, tag identification 0775. *****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: SL39265016-0 On July 28, 2025, through July 30, 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 whom were receiving services under the Assisted Living Facility license. An immediate correction order was identified on July 29, 2025, issued for SL39265016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and	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.	

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0 000	Continued From page 1 the scope and level remain unchanged.	0 000		
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	0 480		

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0 480	Continued From page 2 a two-compartment sink for use only as a handwashing sink; (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 July 28, 2025, for the specific	0 480		

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0 480	Continued From page 3 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a current facility TB risk assessment had been completed for the facility, and failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented	0 660		

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0 660	Continued From page 4 within the proper time frame for one out of two employees, (unlicensed personnel (ULP-B) with employee records reviewed. 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: FACILITY RISK ASSESSMENT On On July 28, 2025, at 1:26 p.m., registered nurse/licensed assisted living director (RN/LALD)-C provided facility risk assessment dated September 15, 2023. RN/LALD-C indicated there was an updated one she could get. On July 28, 2025, at 1:46 p.m., RN/LALD-C stated, "I have the updated (appendix Z) binder but it's in my office (off site) as I was working on it, and I can get it for you whenever you need it. Same with the TB risk assessment, I have the updated one at my office." Surveyor requested the updated TB risk assessment and it was not provided to surveyor. BASELINE TESTING ULP-B was hired on March 25, 2023, to provide direct care services to residents. ULP-B's employee record included a TB blood test dated September 14, 2021. ULP-B's	0 660		

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0 660	Continued From page 5 employee record lacked evidence of baseline TB testing completed on or within ninety days prior to their hire date with the licensee. The licensee's 8.16 Tuberculosis Screening policy, dated October 1, 2022, read, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." The CDC's Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 17, 2023, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB	0 660		

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0 660	Continued From page 6 disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 680		

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0 680	Continued From page 7 licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated 2023, lacked evidence of the following required content: -Documentation of the date of review and any updates made to the plan based on the review; -Documentation of the date of review and any updates made to the EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; -Documentation identifying at risk population needs like maintaining independence, communication, transportation, supervision and medical care; -Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP; -Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; ;Conduct an additional annual exercise that may	0 680		

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0 680	Continued From page 8 include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; -Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed; and -Develop/implement EP policies and procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies -Alternate sources of energy to maintain: -Temperatures to protect resident health/safety -Safe/sanitary storage of provisions -Emergency lighting -Fire detection, extinguishing, alarm systems -Sewage and waste disposal. On July 28, 2025, at 1:46 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "I have the updated (appendix Z) binder but it's in my office (off site) as I was working on it, and I can get it for you whenever you need it." Surveyor requested the updated EP plan and it was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable	0 700		

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0 700	Continued From page 9 relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R2) personal health and medical information was kept private. 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 July 28, 2025, at 10:00 a.m., upon arrival to the facility, surveyor observed the facility computer screen left opened up to RTasks (an electronic charting system used for accessing resident records for medications and treatments) showing resident information, there were two residents in the living room and two staff present in the living room of the facility and the computer was left open and unattended. On July 29, 2025, at 7:47 a.m., surveyor observed unlicensed personnel (ULP)-B provide morning medications to R2. ULP-B opened RTasks on the computer screen and verified R2's medications. The screen displayed all of the	0 700		

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0 700	Continued From page 10 resident's identifying information and medications. ULP-B then went to another area in the facility to pass medications to R2, and did not return to the unlocked computer until 8:03 a.m. The surveyor observed two other staff present in the commons area by the unattended computer. On July 29, 2025, at 8:03 a.m., unlicensed personnel (ULP)-B stated, "I close it when I am done giving the medications, I did not close it because I was not finished giving the medication yet." On July 29, 2025, at 11:17 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "We do HIPPA training and that is yearly, they are trained that they should, when they walk away from the computer close the screen." The licensee's 5.02 Competency Training Evaluations policy dated October 1, 2022, indicated training and competency evaluations for all ULPs will include awareness of confidentiality and privacy and an awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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	39265	A. BUILDING: _____ B. WING _____	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFT HOME CARE SERVICES LLC	14755 91ST PLACE NORTH MAPLE GROVE, MN 55369

(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
0 775	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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: On July 29, 2025, from 1:00 p.m. to 1:40 p.m., the surveyor toured the facility with registered nurse/ licensed assisted living director (RN/LALD)-C, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: EXIT DOOR LOCKING: The main entrance/exit to the house had deadbolt installed on the door that required a key to operate. A lock in the path of egress that required a key to unlock would cause a delay in the proper exiting of the space during a fire or similar emergency. RN/LALD-C visually verified the deficient finding at the time of discovery and removed the deadbolt from the front door at the time of survey. All marked exit doors are required have exit paths maintained from the exit door without locks or latches that require keys, tools, or special	0 775	An immediate correction order was identified on July 29, 2025, issued for SL39265016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged.	

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0 775	Continued From page 12 knowledge. On July 29, 2025, RN/LALD-C stated they did not know they could not have that type of lock on the exit. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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 the potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with registered nurse/licensed assisted living director (RN/LALD)-C. The surveyor asked RN/LALD-C to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The hardwired smoke alarm in the basement was not interconnected with the rest of the smoke alarms in the facility. Existing smoke alarms receiving power from the building electrical system (hardwired) are required to continue as hardwired when replaced. These deficient conditions were visually verified at the time of discovery by RN/LALD-C	0 780		

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0 780	Continued From page 14 accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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.	0 810		

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. This had the potential to directly affect all residents, staff, and visitors. 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: On July 29, 2025, registered nurse/licensed assisted living director (RN/LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 9.06 Fire Policy, dated September 13, 2023, failed to include the following: 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 plan indicated that staff should move residents to be close to an evacuation/exit and wait for the fire department to	0 810		

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0 810	Continued From page 16 arrive and give direction. The FSEP failed to include any procedures for how staff are to evacuate the building. 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. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On July 29, 2025, at 2:45 p.m., RN/LALD-C stated they had updated the staff actions after their last survey but did not have any additional policy that met all the requirements. The licensee failed to provide evacuation training to residents at least once per year. RN/LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On July 29, 2025, at 2:45 p.m., RN/LALD-C stated they offer training to residents when they do the evacuation drills with the staff, but did not have any documentation for it. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 17 (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for two of two residents (R2 and R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted and began receiving assisted living services on February 23, 2024. R2's record included a Assisted Living Contract signed by R2 on February 23, 2024.	0 970		

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0 970	Continued From page 18 R3 R3 was admitted and began receiving assisted living services on May 10, 2023. R3's record included a Assisted Living Contract signed by R3 on May 11, 2023. R2 and R3's Assisted Living Contract indicated, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents. Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended	0 970		

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0 970	Continued From page 19 that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On July 28, 2025, at 12:36 p.m., registered nurse/licensed assisted living director (RN/LALD)-C indicated all residents use the same contract. On July 30, 2025, at 2:04 p.m., RN/LALD-C stated "Yes I agree, we will fix that." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370		

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01370	Continued From page 20 environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a client's health or	01370		

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01370	Continued From page 21 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-A was hired on June 26, 2025, to provide direct care services to residents. On July 28, 2025, at 12:17 p.m., surveyor observed ULP-A assist R4 with a shower. ULP-A's employee records lacked documentation of training and competency evaluations for ULP's providing assisted living services including: - maintenance of a clean and safe environment; and - awareness of commonly used health technology equipment and assistive devices. On July 29, 2025, at 11:22 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "Well I feel like I added those trainings, but I must have missed it and will get them added right away." The licensee's 5.02 Competency Training Evaluations policy dated October 1, 2022, indicated training and competency evaluations for all ULPs will include training on maintenance of a clean and safe environment and an awareness of commonly used health technology equipment and assistive devices. No further information was provided.	01370		

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01370	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01380		

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01380	Continued From page 23 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on June 26, 2025, to provide direct care services to residents. On July 28, 2025, at 12:17 p.m., surveyor observed ULP-A assist R4 with a shower. ULP-A's record lacked the following training and competency evaluations - recognizing physical, emotional, cognitive, and developmental needs of the client. On July 29, 2025, at 11:22 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "Well I feel like I added those trainings, but I must have missed it and will get them added right away." The licensee's 5.02 Competency Training Evaluations policy dated October 1, 2022, indicated training and competency evaluations for all ULPs will include training on recognizing physical, emotional, cognitive, and developmental needs of the client. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 24 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470		

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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
01470	Continued From page 25 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee orientation included all required content for one of three employees (unlicensed personnel (ULP-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-A was hired on June 26, 2025, to provide direct care services to residents. On July 28, 2025, at 12:17 p.m., surveyor observed ULP-A assist R4 with a shower.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39265	A. BUILDING: _____ B. WING _____	07/29/2025

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UPLIFT HOME CARE SERVICES LLC	14755 91ST PLACE NORTH MAPLE GROVE, MN 55369

(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
01470	Continued From page 26 ULP-A's employee records lacked orientation to assisted living regulations to include the following: - Reporting maltreatment of vulnerable adults or minors. On July 29, 2025, at 11:22 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "Well I feel like I added those trainings, but I must have missed it and will get them added right away." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated October 1, 2022, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations which includes training on compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64.	01490		

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01490	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two hours of initial mental illness and de-escalation training were conducted within 160 hours of providing direct care to residents for one of one direct care staff (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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-B was hired on March 25, 2023, to provide direct care services to residents. ULP-B's employee record lacked the following training: -dementia, mental illness, and de-escalation training required for all direct care staff and supervisors. On July 29, 2025, at 11:39 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "So they were all assigned the one hour because I thought they needed to have the one hour done by July 1, So I will assign everyone one more hour." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		

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01620 SS=F	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 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	01620		

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01620	Continued From page 29 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an admission assessment and ongoing nursing assessments not to exceed every 90-days for two of two residents (R2 and R3). 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: R2 R2 was admitted to the licensee and began receiving services on February 23, 2024. R2's diagnoses included hypertension, atrial fibrillation, kidney disease, and antisocial personality disorder.	01620		

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01620	Continued From page 30 R2's unsigned Service Plan (Waiver) dated effective March 16, 2024, indicated R2 received assistance with bathing, bedmaking, compression stockings, dressing, grooming, housekeeping, incontinence care, laundry, linen change, behavior management, vitals, toileting, transfer assist, and wound care. R2's record included a comprehensive assessments dated November 12, 2024, April 11, 2025, and July 15, 2025, indicating 150 days and 95 days respectively had passed between assessments. R3 R3 was admitted to the licensee and began receiving services on May 10, 2023. R3's diagnoses included diabetes, anxiety, hypertension, and post tramatic stress disorder. R3's Service Plan (Waiver) dated May 11, 2023, indicated R3 received assistance with ambulation, bathing, dressing, housekeeping, incontinence care, behavior management, medication administration, and vitals. R3's record included a comprehensive assessments dated January 25, 2025, and July 28, 2025, (after survey had started) indicating 184 days had passed between assessments. On July 29, 2025, at 9:53 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "So, I don't think I am late because assessments are supposed to be done at 14 days, 30 days, 90 days and then every year after that, so I am ok because I did it in November of [2024] and again [April] and [July] of	01620		

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01620	Continued From page 31 [2025]." On July 30, 2025, at 2:04 p.m., RN/LALD-C acknowledged that the assessments were late for all the residents due to the electronic charting system (rtasks) they use assigning dates. RN/LALD-C stated, "Yes that rtasks messed me up but now I will get it fixed." The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated October 1, 2022, 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 provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 32 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted to the licensee and began receiving services on February 23, 2024. R2's diagnoses included hypertension, atrial fibrillation, kidney disease, and antisocial personality disorder.	01640		

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01640	Continued From page 33 R2's unsigned Service Plan (Waiver) dated effective March 16, 2024, indicated R2 received assistance with bathing, bedmaking, compression stockings, dressing, grooming, housekeeping, incontinence care, laundry, linen change, behavior management, vitals, toileting, transfer assist, and wound care. R2's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On July 29, 2025, at 9:48 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "What I remembered is Jahi is partially blind so he can't even see the box to sign so I had to hold his hand and place it where he would sign, and I felt like I was then writing his name so I didn't have him do the signing because he can't see where to sign it anyway." The licensee's 6.08 Service Plan policy, dated October 1, 2022, indicated, "Within 14 days after the date that services are first provided to a resident, [Licensee] will finalize a written service plan. The service plan and any revisions shall include a signature or other authentication by [Licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01880	Continued From page 34	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 28, 2024, at 11:20 a.m., the surveyor observed the kitchen refrigerator that was unsecured and open for the residents use, held four bottles of Latanoprost 0.005 percent eye drops for R2, nine unopened Lantus insulin pens for R3, and three injection solutions of Trulicity for R3. On July 28, 2025, at 1:27 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "The only medications that are in there are eye drops and insulin so when	01880		

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01880	Continued From page 35 staff go to the fridge there are staff present so they make sure they don't touch that. But we have a lock box we can use, and we can start that right away." The Licensee's 7.11 Medication Storage policy dated, October 1, 2022, indicated, "Medications managed by [Licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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01910	Continued From page 36 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of two discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving services on April 13, 2023. R1 passed away and was discharged from the facility on March 9, 2025.	01910		

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01910	Continued From page 37 R1's record included a resident note dated March 9, 2025, that read, "Hospice controlled substance were destroyed by hospice nurse with writer as a witness." R1's record lacked a medication disposition to include including the prescription number as applicable, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for diazepam 5mg (miligrams), oxycodone 10mg, hyoscyamine 0.125 mg, prochlorper 5mg, morphine sulfate 5mg, methadone 5mg, and alprazolam 0.5mg. On July 30 2025, at 2:04 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "I understand what is needed, but those meds were from hospice so I thought hospice would be responsible for doing that." The licensee's 7 .23 Medication Disposal policy, dated October 1, 2022, indicated, "The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Uplift Home Care Services
14755 91st Place North
Maple Grove, MN 55369
Hennepin County
Parcel:

Phone: 7632451192

License Info

License: 0042061

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Kuria Caroline
CFPM #: 24285; Exp: 05/27/2028

Inspection Info

Report Number: F1051251068
Inspection Type: Full - Single
Date: 7/28/2025 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
AT THE TIME OF INSPECTION, MILK AND DELI TURKEY MEASURED 47 DEG F IN THE KITCHEN UPRIGHT COOLER. THE DELI TURKEY WAS DISCARDED ON-SITE. ADJUST THE UNIT TO A COOLER TEMPERATURE.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, TESA BROWN.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, KURIA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
COLD HOLDING
HANDWASHING AND GLOVE USE/DISPOSAL

THE KITCHEN HAS VINYL WOODEN FLOORS, LAMINATE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, A NSF 184 DISHWASHER, AND A SMOOTH TEXTURE CEILING.

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 St Cloud District Office inspection report number F1051251068 from 7/28/2025

Kuria Caroline

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Uplift Home Care Services
Maple Grove
County/Group: Hennepin County

Inspection Info

Report Number: F1051251068
Inspection Type: Full
Date: 7/28/2025
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: DELI TURKEY**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 47 Degrees F.
Comment:
Violation Issued?: Yes