Electronically Delivered

January 2, 2025

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

RE: Project Number(s) SL35706015

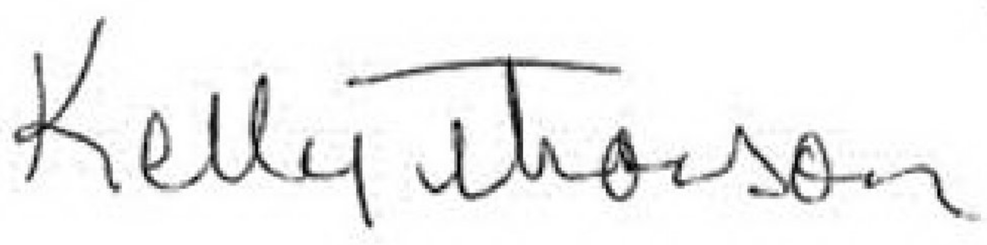
Dear Licensee:

On November 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 15, 2024, survey were corrected. 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,



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

HHH

Electronically Delivered

September 18, 2024

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

RE: Project Number(s) SL35706015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 15, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

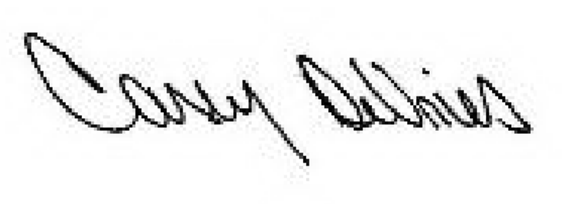
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	08/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35706015-0 On August 12, 2024, through August 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living Facility license. An immediate order for correction was identified on August 13, 2024, issued for SL35706015-0, tag identification 1290. On August 13, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate order for correction was identified on August 14, 2024, issued for SL35706015-0,	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 tag identification 0820. On August 15, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (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	0 470		

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0 470	Continued From page 2 by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation completed by a registered nurse (RN) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2024, at 10:24 a.m., on the main level of the three-story home, in the main common area there was a board which displayed an undated document titled Facility Staffing Plan. The document indicated it was prepared by owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C. The document lacked a date of when the document was completed or last reviewed. On August 14, 2024, at 9:35 a.m., the surveyor requested the licensee's staffing plan. Owner/agent (O/A)-A pointed to the document posted on the display board. O/A-A stated they were aware the licensee required a staffing plan but was not aware it had to be updated twice a year.	0 470		

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0 470	Continued From page 3 On August 14, 2024, at 9:38 a.m., O/CNS/LALD-C stated they were aware of the staffing plan was required to be evaluated twice a year and they forgot sign and date the plan. The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor (CNS) would develop and implement a writing staffing that provides an adequate number of qualified direct-care staff to meet the residents needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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	0 480		

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0 480	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, R2).	0 630		

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0 630	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses include schizophrenia (mental disorder that may result in hallucinators that may include hearing and seeing things that are not observed by others, delusions, and disorganized thinking). R1's IAPP dated July 30, 2024, indicated R1 was at risk to be abused by others, however, did not include the following required content: -the person's risk of abusing other vulnerable adults. R2 R2 discharged from the facility March 7, 2024, and was re-admitted back to the licensee on April 19, 2024. R2's diagnoses include undifferentiated schizophrenia (mental disorder that may result in hallucinations, delusions, or disorganized speech). R2's IAPP dated October 2, 2023, indicated R2 was at risk to be abused by other people with a nurse intervention of the client (resident) required	0 630		

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0 630	Continued From page 6 24-hour supervision. The IAPP indicated R2 was at risk to abuse other people with a nurse intervention that R2 hits and to look for knives. R2 medical record contained a progress note dated March 7, 2024, that indicated police were called to the facility as R2, "lunged a knife at staff." The progress note indicated R2 was taken into custody by police. R2 IAPP dated July 7, 2024, indicated R2 was not at risk to be abused by other people with a nurse invention of staff to monitor and supervise all the time. The IAPP indicated R2 was at risk to abuse other vulnerable adults with a nurse intervention of staff to monitor residents all the time and give medications on time. R2's IAPP lacked new interventions to prevent R2 from abusing other people based on prior behaviors. On August 13, 2024, at 2:07 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C stated the licensee removed all knives from the facility and stated the intervention was documented in the medical record. The surveyor observed O/CNS/LALD-C using an electronic tablet to search R2's medical record on RTasks (a software medical chart documentation program). O/CNS/LALD-C stated they were unable to locate the documented new intervention. On August 13, 2024, at 2:29 p.m., owner/agent (O/A)-A stated they held a meeting with staff via an online video conference to discuss the interventions required for R2. O/A-A stated staff were instructed to check R2's room for knives and that should have had been documented.	0 630		

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0 630	Continued From page 7 O/A-A stated it was a mistake for not including that information in the medical chart. On August 14, 2024, at 9:36 a.m., O/CNS/LALD-C stated they were aware of the required content for the IAPP and was an oversight for not updating and missing the content on the IAPP. On August 14, 2024, at 9:55 a.m., O/A-A stated the registered nurse was responsible for completing the IAPP and was a mistake for missing the required information. The licensee's 6.05 Individual Abuse Prevention Plan dated August 1, 2021, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adults and will include an individualized review or assessment of the person's susceptibility to be abused by another individual and the person's risk of abusing other people and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 8 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 observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-B, ULP-D) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 650		

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0 650	Continued From page 9 ULP-B ULP-B was hired on October 1, 2021, to provide direct care services. On August 13, 2024, at 7:06 a.m., the surveyor observed ULP-B administering medications to R1, R2 and R3. ULP-B's employee file lacked the following content: -current job description; and -annual reviews. ULP-D ULP-D was hired on September 30, 2022, to provide direct care services. ULP-D's employee file lacked the following content: -current job description. On August 14, 2024, at 9:40 a.m., owner/agent (O/A)-A stated they were aware a current job description and annuals reviews were to be included in the employee file and stated the documentation may have been misplaced. On August 14, 2024, at 9:42 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C stated they were aware a job description and annual reviews should be available in the employee file. O/CNS/LALD-C stated they may have misplaced the documentation. The licensee's 4.05 Employee Records dated August 1, 2021, indicated the licensee would include a current job description and would perform annual reviews for employees.	0 650		

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0 650	Continued From page 10 No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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 licensee failed to maintain a written emergency preparedness plan (EPP) with all the required	0 680		

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	35706	A. BUILDING: _____ B. WING _____	08/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 content as defined in Appendix Z. 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 February 20, 2024, lacked evidence of the following required content: - risk assessment of interruption of services and consider emerging infectious diseases; - population needs: independence, communication, transportation, supervision and medical care; - identify staff specific roles in another's absence through succession planning and delegation of authority; - subsistence needs for staff and patients; - procedures for tracking staff and patients; - policies and procedures including evacuation; - policies and procedure for sheltering; - policies and procedures for volunteers; - written communication plan; - names and contact information for staff entities providing services under agreement, residents physicians, other facilities, volunteers; - methods for sharing information; - sharing information on occupancy/needs and; - long-term care (LTC) family notifications. On August 14, 2024, at 9:47 a.m., owner/agent	0 680		

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0 680	Continued From page 12 (O/A)-A stated they were aware the licensee was required to have an EP plan for the assisted living facility but was not aware of the required content. On August 14, 2024, at 9:50 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C stated they were aware of the required content and the licensee hired a consultant company to assist with creating the EP plan. O/CNS/LALD-C stated they believed the current EP plan was compliant with 144G statutes. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an emergency preparedness plan that is in alignment with the facility's requirements to comply with Center for Medicare and Medicaid Services (CMS) appendix Z. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 13 of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 the potential to affect a large portion or all of the residents). The findings include: On August 14, 2024, at 1:15 p.m., survey staff toured the facility with owner/agent (O/A)-A. During the tour, the surveyor observed when smoke alarms were tested in resident bedrooms and outside the sleeping areas, none of the other	0 780		

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0 780	Continued From page 14 smoke alarms in the dwelling unit were actuated. During the facility tour interview on August 14, 2024, O/A-A verified the dwelling unit smoke alarms were not interconnected as required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 15 The findings include: On August 14, 2024, at 1:15 p.m., survey staff toured the facility with owner/agent (O/A)-A. During the tour, the surveyor observed the following: - The door leading to a rooftop terrace enclosed by railings was improperly labeled as an exit on the posted floor plan. - One railing was loose on the rooftop terrace. - In unoccupied bedroom 2, the operator arm became disconnected when O/A-A opened the egress window. Egress windows must be maintained in proper operating condition to allow the occupant to safely exit the building in the event of an emergency. - In the office area, two power strips were daisy-chained together, creating a fire hazard. - The duct was disconnected on the clothes dryer vent in the basement. During the facility tour interview on August 14, 2024, O/A-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 16 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 17 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 14, 2024, owner/agent (O/A)-A 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 had not developed and maintained a FSEP evident by a record review of the available documentation. The FSEP included a fire safety policy dated December 7, 2023. This fire safety policy was a template from a third-party provider and was not developed for use at this facility location. The policy referenced installation locations for 3 portable fire extinguishers and only one was observed during the facility tour. During an interview on August 14, 2024, at 3:30 p.m., O/A-A verified the fire extinguisher locations were not accurate in the policy. 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 evident by a lack of these actions in the plan. The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. During an interview on August 14, 2024, at 3:00 p.m., O/A-A verified the FSEP required revision. TRAINING	0 810		

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0 810	Continued From page 18 Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by no training records. During an interview on August 14, 2024, at 3:00 p.m., O/A-A stated residents participated in the facility fire drills and no additional training had been completed. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. A post-test, dated January 2, 2024, for annual employee training on the handling of emergencies and use of emergency services was provided. No training records were provided to support employee training on the facility FSEP had been completed. During an interview on August 14, 2024, at 3:00 p.m., O/A-A verified FSEP training had not been completed with employees at the frequency required by statute. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required frequency and documentation. Two fire drills were recorded in 2024, dated April 20, 2024, and June 26, 2024. The time or shift was not recorded for the 2024 drills. One fire drill was recorded in 2023, dated August 4, 2023. During an interview on August 14, 2024, at 3:00 p.m., O/A-A verified the evacuation drill frequency was not met and the required information had not been recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820	Continued From page 19	0 820		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 14, 2024, at 1:15 p.m., survey staff toured the facility with owner/agent (O/A)-A. The	0 820		

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0 820	Continued From page 20 egress windows in resident bedrooms were opened by O/A-A. Survey staff measured the clear open area of the windows. The windows in bedrooms 3 and 4 did not meet the minimum requirements for safe egress. Egress window measurements: Occupied resident bedroom 3 - the clear open area of the egress window measured 15.5 inches width, 42 inches height, with a total clear area of 651 square inches, and was obstructed by the window opening hardware. Occupied resident bedroom 4 - the clear open area of the egress window measured 18 inches width, 43 inches height, with a total clear area of 774 square inches, and was obstructed by the window opening hardware. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). Window hardware must not obstruct the total clear area of the egress window. During the facility tour interview, O/A-A verified the egress window measurements and the window hardware obstruction. TIME PERIOD FOR CORRECTION: Immediate On August 14, 2024, at 1:15 p.m., survey staff toured the facility with owner/agent (O/A)-A. During the tour, the surveyor observed an exit sign posted above the back door and a key only locked was installed on this door. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in	0 820		

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0 820	Continued From page 21 the event of an emergency. During the facility tour interview on August 14, 2024, O/A-A, verified the improper locking arrangement on this door. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit plan review applications and obtain permits for installation of egress windows in resident bedrooms. 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 the potential to affect a large portion or all of the residents). The findings include: On August 14, 2024, at 1:15 p.m., survey staff toured the facility with owner/agent (O/A)-A. The surveyor observed new windows were installed in resident bedrooms. During the facility tour	0 830		

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0 830	Continued From page 22 interview on August 14, 2024, O/A-A stated the bedroom windows had been replaced in March and June 2024. O/A-A explained permits and plan review applications had not been submitted for these projects. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-B). This resulted in an immediate correction order issued on August 13, 2024. This practice resulted in a level three violation (a	01290		

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01290	Continued From page 23 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 finding include: ULP-B was hired on October 1, 2021, to provide direct care services to residents. On August 13, 2024, at 6:45 a.m., licensee provided the surveyor with the facility's NETStudy 2.0 roster (a web-based system used for submitting background study requests to the Department of Human Services) for health facility identification number (HFID) 35706. On August 13, 2024, at 7:06 a.m., the surveyor observed ULP-B providing medication administration to R1, R2, and R3. ULP-B's background study affiliated to licensee's HFID 35706, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the Minnesota Department of Human Services NETStudy 2.0 website roster page. On August 13, 2024, at 8:04 a.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C stated all employees were required to have a cleared background study prior to providing direct care services to residents. O/CNS/LALD-C stated the background study was not expired. O/CNS/LALD-C showed the NETStudy 2.0 roster to owner/agent (O/A)-A.	01290		

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01290	Continued From page 24 On August 13, 2024, at 8:08 a.m., the surveyor observed O/A-A reviewing the Minnesota Department of Human Services NETStudy 2.0 website. O/A-A showed the surveyor the roster for HFID 35706. The website indicated the background check for ULP-B was expired. O/A-A stated all employees were required to have a cleared background study before providing cares to residents. O/A-A stated it was not an oversight as the Minnesota Department of Human Services did not alert [licensee] the background check had expired. O/A-A stated they did not know the COVID-19 background checks expired. On August 13, 2024, at 8:15 a.m., O/CNS/LALD-C stated they were unaware the background check had expired. On August 13, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35706	A. BUILDING: _____ B. WING _____	08/15/2024

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

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01290	Continued From page 25 rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's 4.02 Background Studies dated August 1, 2021, indicated no employee may provide direct care services until an acceptable result of the background study was received. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

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01650	Continued From page 26 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required service plan content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the facility on April 19, 2024, and began receiving services. R2's medical file contained an undated and unsigned document titled Service Plan Form that indicated R2 received assistance with assistance with dressing, setting up food, hygiene, grooming, toileting, bathing reminders, medication administration, laundry, housekeeping, and linen	01650		

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01650	Continued From page 27 change. The service plan lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing the service; - a contingency plan that included; - action to be taken if the scheduled service cannot be provide; - information and a method to contact the facility, and; - the names and contact information of persons the resident wishes to have notified in an emergency. On August 15, 2024, at 8:59 a.m., owner/agent (O/A)-A stated they were unaware there was missing content from R2's service plan, and it was an oversight for not including the required information. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated; ""2. The service plan and any revisions shall include a signature or other authentication by Upend HHC and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring. 4. Services plans shall include fees for the services indicated in the service plan. 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment	01650		

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01650	Continued From page 28 and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions Upend HHC will take if scheduled services cannot be provided ii. Information regarding how the resident can contact Upend HHC iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any -including circumstances when emergency medical services are not to be summoned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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	01910		

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01910	Continued From page 29 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 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 include the medication name, medication strength, prescription number, quantity, and to whom the medications were given for one of one discharged 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, 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 discharged from the assisted living facility on March 7, 2024.	01910		

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01910	Continued From page 30 R1's medication administration record dated March 1, 2024, through March 7, 2024, indicated R1 received the following medications trazadone 50 milligram (mg) 1 tablet at bedtime, Abilify 400 mg injection intramuscularly (into a large muscle) once per month, Glucophage extended release (ER) 1 tablet once daily, olanzapine 5 mg twice daily as needed, levothyroxine 75 micrograms (mcg) once daily, sertraline 50 mg once daily, Vitamin D3 25 mcg once daily, melatonin 3 mg once daily at bedtime, and olanzapine 5 mg 1 daily at bedtime R1's medical record lacked evidence the licensee had performed the required medication disposition upon discharge. On August 13, 2024, at 12:24 p.m., owner/clinical nurse supervisor/licensed assisted living director (O/CNS/LALD)-C stated when R1 discharged from the facility, R1 only had a two or three day supply of their medications remaining. O/CNS/LALD-C stated they counted the medications and disposed of them but could not locate the documentation. On August 13, 2024, at 12:26 p.m., owner/agent (O/A)-A stated they counted the medications but were not able to locate the documentation. The licensee's 7.23 Medication Disposal policy dated August 1, 2022, indicated when a resident discharges from the facility they 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.	01910		

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01910	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *08/12/24*
Time: 11:41:02
Report: 8058241189

Food and Beverage Establishment Inspection Report

Location:
Upend Home Health Care
1698 Beech Street
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0038336
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129618570
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 50 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL HOME, NON COMMERCIAL APPLIANCES AND FINISHES

HRD INSPECTOR KEITH LANGLEY

COOLER ADJUSTED DURING INSPECTION AND TEMPERATURE DROP VERIFIED VIA PHOTO

DISH TEMP VERIFIED BY PHOTO

Type: Full
Date: *08/12/24*
Time: 11:41:02
Report: 8058241189
Upend Home Health Care

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058241189 of 08/12/24.

Certified Food Protection Manager: SUAD A ISSE

Certification Number: 71340 Expires: 01/18/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us