

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL380083462M
Compliance #: HL380086537C

Date Concluded: July 24, 2025

Name, Address, and County of Licensee

Investigated:

Universal Healthcare Solutions
8119 Upton Avenue
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The alleged perpetrator (AP 1), who is a registered nurse (RN), licensed assisted living director (LALD), and owner of the facility neglected the resident (resident 2) when they failed to provide a safe environment for the resident when a fire occurred, resulting in the resident going to the hospital.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility, AP 1 and AP 2 were responsible for the maltreatment. AP 2 was identified during the investigation and worked as an unlicensed personnel. A fire occurred at the facility due to a resident (resident 1) who used oxygen therapy attempted to smoke in his room. AP 2 failed to develop a fire evacuation plan that provided directive to staff on the proper steps to take on determining evacuation of residents. Fire drills and staff training were documented completed at the facility and AP 2 participated in evacuation drills. During the fire, AP 2 left a transfer and mobility

dependent resident (resident 2) in bed to go assist an independent mobile resident (resident 3) out of the facility during the fire.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the fire department and law enforcement. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the external fire damage at the facility.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included pre-excitation syndrome (a condition of the heart caused by abnormal electrical activity), heart failure and psychosis. Resident 2's service delivery record indicated he received assistance with mobility, toileting, dressing and medication administration.

Resident 2's assessment indicated he was alert, oriented and required one person assistance with transfers, and used a wheelchair. The assessment indicated he was non ambulatory and needed full assistance from staff for evacuation in emergencies.

Resident 2's individual abuse prevention plan (IAPP) indicated he required full assistance during emergencies and was not able to evacuate independently. The IAPP indicated in case of a fire, staff must ensure resident 2 is safely escorted out of the building or relocated to the nearest safe spot.

Resident 3's assessment indicated she was self-ambulatory with a walker and self sufficient. Resident 3 required no assistance from staff during an evacuation.

Resident 1's assessment indicated he was non-ambulatory and used a wheelchair. Resident 1 was dependent on staff for all movement.

Resident 1's IAPP indicated resident 1 was not able to evacuate during a fire and required to be evacuated via a wheelchair or stretcher by assigned staff, included on the evacuation roster.

The facility Fire Safety and Evacuation Plan, created by AP 1 and reviewed by the AP 2, lacked directive to staff on what steps to take during an evacuation specific to the facility. The plan indicated generically residents will follow the RACE (rescue, alarm, contain, evacuate) procedure in collaboration with staff, in the event of a fire. The plan indicated residents who can assist in their own evacuation shall be trained on proper actions to take in the event of a fire to include movement, evacuation, or relocation at least once a year. The plan failed to identify an evacuation roster and direct staff which residents required evacuation first due to mobility dependence.

The facility fire safety training document indicated resident's should "get out and stay out." The training indicated there were two exits from the resident's bedrooms. The training indicated the resident should clear all clutter that may block their escape and meet at the end of the driveway. The facility had all resident's sign the fire training safety, although resident 2 or resident 1 were not physically capable of executing the plan.

A fire drill conducted approximately 2.5 months before the fire indicated AP 1 initiated the drill and AP 2 participated in evacuating residents. Two residents were evacuated in the drill, but the record failed to indicate which residents participated in the drill.

A fire drill conducted approximately three weeks prior to the fire indicated AP 1 initiated the drill and lead evacuation. AP 2 was not apart of the drill. The drill indicated residents who were capable of assisting in their own evacuation participated. Resident 1 refused to participate.

A facility incident report indicated 911 was called due to a fire emergency when staff heard a smoke detector sound. The report indicated staff observed a fire in room three [resident 1's room]. The report indicated the fire department arrived to help with the fire, and residents were evacuated to another facility.

A written statement from AP 2 indicated AP 2 was worked at the facility when the fire happened. AP 2's statement indicated she had completed cares, assisted a resident 1 to lay down in bed, and proceeded to go to resident 2's room to assist him when she heard a smoke detector sounding. Upon inspection of the alarm sounding, AP 2's statement indicated she saw fire coming out of resident 1's room. The statement indicated AP 2 ran to get the fire blanket while calling 911. The statement indicated the fire became too much for AP 2 to enter resident 1's room, so AP 2 closed other facility room doors, including resident 2's room where resident 2 was in bed, and ran to the basement to alert an ambulatory resident [resident 3] of the fire. The statement indicated AP 2 and resident 3 exited the facility and waited outside while the fire department arrived. The report indicated the fire department evacuated resident 2 from the facility.

During an interview, resident 2 stated he needed help from staff to get in and out of his wheelchair. Resident 2 stated staff had not talked to him about what to do in the event of a fire, and he had not practiced a fire evacuation. Resident 2 stated on the day of the fire, he saw black smoke coming up and he yelled for help. Resident 2 stated he did not know where the staff was, so he got himself out of the facility by crawling out. Resident 2 stated the fire department staff brought their medical bag to him and brought him to the hospital. Resident 2 stated he did not have any injuries from the fire. Resident 2 stated he was afraid for his life and was very scared that day.

During an interview, AP 1 stated he contacted a consult company to develop a fire safety plan to include steps for residents and staff to follow in the event of a fire. AP 1 stated each resident

had an individualized fire plan for them that they and staff were educated on and had practiced. AP 1 stated staff knew what to do and were trained about four times a year.

During an interview, a registered nurse (RN) stated the nurses make sure staff are trained on fire safety and evacuation. The RN stated they do drills since they are very important. The RN stated when a resident admits to the facility, the nurses make sure the resident and staff are trained, and the resident care plans are updated.

During an interview, AP 2 stated she was sufficiently trained on what to do in the event of a fire. AP 2 stated she participated in fire drills, but the residents did not practice or do drills. AP 2 stated she knew how each resident transferred and what type of assistance they needed for evacuation as it was stated in their care plans. AP 2 stated on the day of the fire, she was in resident 2's room assisting him when she heard the smoke detector sounding. AP 2 stated when she looked to see what was going on, she saw a large fire coming out of resident 1's room and could not enter the room due to the size of the fire. AP 2 stated she shut the door of resident 2's room while on the phone with 911 and ran to the basement to notify resident 3 of the fire. AP 2 stated she exited the facility with resident 3 and the fire department would not let her re-enter the facility.

Family did not respond to the investigators request for interview.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

- (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
- (iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
- (v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
- (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) AP 1 and AP 2 did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility and AP 1 did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP 1 and AP 2 followed the facility directive and/or policies and procedures.

AP 1 had the authority to direct and implement operational regulatory requirements or make operational changes.

(3) AP 1 and AP 2 failed to follow professional standards and/or exercise professional judgement.

AP 1 and AP 2 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: No, did not return request for interview.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility activated emergency services and relocated the resident to a safe location.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Bloomington City Attorney

Bloomington Police Department

Board of Executives for Long Term Services and Supports

Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2025
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTHCARE SOLUTIONS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8119 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431		
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0 000	Initial Comments *****ATTENTION*** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL380086547C/HL380083402M HL380086537C/HL380083462M On June 10, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were zero (0) residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL380086547C/HL380083402M and HL380086537C/HL380083462M, tag identification 100, 250, 1060, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100			

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0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a building to operate at the address location of their assisted living license and provide services to three of three residents (R2, R3, R4) reviewed. 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's diagnosis includes psychosis and pre-excitation syndrome. R2's service delivery record dated June 9, 2025, indicated R2 received assistance with toileting, mobility, and behavior management.	0 100			

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0 100	Continued From page 3 R3's diagnoses included anxiety, hypertension, and scoliosis. R3's service plan dated June 24, 2025, indicated R3 received assistance with activities, bathing reminders, dressing, grooming, medication administration, toileting, meal assistance, and transfer assistance. R4's diagnosis included bipolar disorder. R4's service delivery record dated June 10, 2025, indicated R4 received assistance with safety checks and behavior management. A facility incident report dated June 4, 2025, at 6:38 p.m., indicated there was a fire in room #3 of the facility (address #1) and 911 was called. The report indicated all residents were evacuated to another facility. During an onsite visit on June 10, 2025, at 8:45 a.m., the investigator observed the status of the facility located at the licensee address #1. The fire damage was still present, with the noted smoke damage across various exterior locations of the facility and a boarded-up window. The investigator was not able to enter the facility. During an onsite visit on June 10, 2025, at 9:59 a.m., the investigator entered a facility the licensee was operating at, address #2, where R2, R3 and R4 discharged to. R2 and R4 were present during the onsite visit. R3 discharged to another facility the day prior to the onsite visit. An email dated June 16, 2025, at 8:30 a.m., from licensed assisted living director (LALD)-B, indicated LALD-B planned to reopen address #1 once repairs are made. The facility license issued from the Minnesota Department of Health indicated the licensee has	0 100			

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0 100	Continued From page 4 an active license for address #1 that will expire November 18, 2025. During an interview on June 24, 2025, at 12:10 p.m., LALD-B stated he has operated address #1 since 2021, and address #2 since 2024. LALD-B stated R3 was taken to address #2 by staff during the fire incident at address #1. LALD-D stated he notified R3's family right away of the move, and R2's family the next day. LALD-D stated he has insurance to take care of the damage at address #1 and planned to bring the residents back once cleared to do so. LALD-B stated the residents want to return to address #1. LALD-B stated he was advised by a construction company the repairs could take up to approximately six months. During an interview on July 1, 2025, at 12:00 p.m., unlicensed personnel (ULP)-D stated she is currently not working due to the fire at address #1, as there are no residents there and no hours available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 100			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;	0 250			

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0 250	Continued From page 5 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or	0 250			

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0 250	Continued From page 6 (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and observation, the licensee failed to provide a habitable facility for residents after the facility sustained a fire. This affected 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: A facility incident report dated June 4, 2025, at 6:38 p.m., indicated a fire alarm sounded, and a fire was observed by staff coming from room #3. The report indicated 911 was called, the fire department arrived, and all residents (R2, R3, R4) were evacuated to another facility (address #2). During an onsite visit on June 10, 2025, at 8:45 a.m., the investigator observed the status of the facility located at the licensee address (address #1). The investigator was unable to enter the facility. External fire and smoke damage was	0 250			

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0 250	Continued From page 7 observed across various external locations of the facility. A window at the front of the facility was observed to be boarded up. A black charred smoke detector was lying on the front step of the facility, chirping. During an interview on June 24, 2025, at 12:10 p.m., licensed assisted living director (LALD)-B stated the residents were moved to the second facility he owns (address #2), where they receive all services and had all their needs met. LALD-B stated he was working with insurance to repair the damage and plans to bring the resident's back to the facility once the facility is cleared. LALD-B stated the construction company stated it could take up to six months to complete the repairs. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060			

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01060	Continued From page 8 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to timely provide written notices of emergency relocation of residents to their families, case managers, and the Ombudsman, as required, for three of three residents (R2, R3, R4) reviewed. 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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2025
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTHCARE SOLUTIONS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8119 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431		
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01060	Continued From page 9 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnosis included psychosis and pre-excitation syndrome. R2's service delivery record dated June 9, 2025, indicated R2 received assistance with toileting, mobility, and behavior management. R3's diagnoses included anxiety, hypertension, and scoliosis. R3's service plan dated June 24, 2025, indicated R3 received assistance with activities, bathing reminders, dressing, grooming, medication administration, toileting, meal assistance, and transfer assistance. R4's diagnosis included bipolar disorder. R4's service delivery record dated June 10, 2025, indicated R4 received assistance with safety checks and behavior management. A facility incident report dated June 4, 2025, at 6:38 p.m., indicated a fire alarm sounded and a fire was observed by unlicensed personnel (ULP)-D coming from facility room #3. The report indicated 911 was called, the fire department arrived, and residents R2, R3, and R4 were evacuated to another facility (address #2), operated by the licensee. The licensee provided document titled "Unihealthcare Solutions" dated June 30, 2025, indicated it was the emergency transfer notice. The same letter was provided to the case managers of R2, R3, and R4.	01060			

Minnesota Department of Health

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01060	Continued From page 10 The licensee lacked documentation the Ombudsman was provided the emergency relocation notice when residents were not able to return to the licensee location after four days [by June 8, 2025]. An email on June 16, 2025, at 8:39 a.m., from licensed assisted living director (LALD)-B to the investigator, indicated relocation notices were being mailed that week. An email from LALD-B to the investigator, dated July 10, 2025, at 10:47 a.m., indicated written notifications of the relocation of R2, R3, and R4 to the Ombudsman were being sent July 10, 2025. LALD-B stated in the email that the families of R2, R3, and R4 were notified by phone call. During an interview on June 24, 2025, at 12:10 p.m., LALD-B stated when he arrived on site at the facility during the fire, he arranged for other staff to drive R3 to the other facility (address #2). LALD-B stated he notified R3's family the same night, and R2's family the next day. TIME PERIOD FOR CORRECTION: Seven (7) days	01060			
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s)	02360			

Minnesota Department of Health

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02360	Continued From page 11 reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual persons were responsible for the maltreatment for R1 and R2, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360			