Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL380083402M
Compliance #: HL380086547C

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
Rhylee Gilb, 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 facility and AP neglected the resident when they failed to properly supervise the resident, which resulted in a facility fire and the death of the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the AP were responsible for the maltreatment. While the AP, the facility licensed assisted living director, registered nurse (RN) and owner, completed room checks for smoking materials three times a week and provided education to the resident about smoking safety, the AP failed to assess the resident as he continued with non-compliance with the smoking policy and implement new interventions. Additionally, the facility failed to document and the resident's observed behaviors of smoking in his room prior to the about fire safety. The AP's

documentation of room checks being clear from contraband did not match staff's documentation of finding smoking materials on the resident. The resident used oxygen and started a fire in his room. Staff were unable to evacuate the resident and he died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident records, staff and resident fire safety training records, facility fire drill logs, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The resident's death record remained unavailable during the investigation. Also, the investigator observed external fire damage to the facility while on site. The investigator was not able to access the inside of the facility while on site.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, legal blindness, and chronic obstructive pulmonary disease. The resident's service plan included assistance with dressing, mobility, medication administration oxygen delivery, safety checks, transfers and toileting. The resident's assessment indicated the resident was non ambulatory, used a wheelchair, used oxygen therapy, and was alert and oriented.

The resident's smoking assessment indicated the resident was a smoker, and staff assisted him to and from the smoking area. The assessment indicated smoking materials were kept in the resident's room. The assessment indicated the resident did not dispose of cigarette butts properly by himself and did not extinguish cigarettes completely, yet the assessment also indicated he independently smoked safely.

A facility policy titled "Smoking/Tobacco Use," signed by the resident indicated the resident agreed to follow the rules of the facility smoking policy. The policy indicated a second smoking policy violation would result in a 30-day notice to vacate the facility. Two months after the policy was signed (approximately four ½ months prior to the fire), the resident signed acknowledgement of a second violation for smoking in the room. Two additional dates were hand-written on the form, with time of the day, however there was no additional context to what those dates signified or if those were additional dates of smoking violation.

Three weeks later, a care conference progress notes indicated the resident, his case manager, and the AP participated in the conference and discussed the resident's current health status and on-going need for smoking safety due to high-risk status. The noted indicated the resident was "cooperative" but continued to be high risk for smoking-related injury due to oxygen use. The resident verbally agreed he understood the smoking protocol and would continue to notify staff for supervised smoking. The follow-up progress note indicated the resident was educated about the dangers of smoking in an oxygenated room. The resident verbally agreed to not attempt smoking in his room.

The resident's progress notes the following day indicated a room search log was created to ensure the resident did not have smoking materials in his room, and all smoking materials were locked in the medication room. The notes indicated the RN was to complete person searches three times a week and staff were to complete room and/or body searches as needed when completing night cares.

The room search log indicated room checks were complete three times a week starting four months prior to the fire.

Two months later, the resident's progress notes indicated staff assisted the resident outside to smoke four times during an evening shift and staff observed the resident hiding cigarettes in the pocket of his shirt. The note indicated staff provided education to the resident about smoking dangers with oxygen in his room.

The log noted on the same date; staff found cigarettes in the resident's room during the room checks. The log indicated cigarettes and lighter were found inside a pillow.

A month later, the resident's progress notes indicated the resident attempted to hide cigarettes in his pocket after staff assisted him with smoking and threatened to have staff fired if they tried to check for cigarettes.

The log however, signed by the AP on the date, indicated there was "nothing found."

During an interview, another resident (resident 2) stated he saw the resident smoking inside the facility several times and heard staff tell him not to do that several times. Resident 2 said staff would tell the resident not to smoke inside and would take his smoking stuff away.

During an interview, an unlicensed personnel (ULP) stated she assisted the resident outside to smoke after taking his oxygen off in his room. The ULP stated another resident helped the resident light his cigarette and staff stay with the resident when he smoked. The ULP stated the resident did not need any other assistance with smoking. The ULP said the resident hid cigarettes in his pockets and he attempted to smoke in his room prior to the fire.

The resident's record lacked documentation of resident 2 and the ULP's observations of the resident smoking in his room.

The AP failed to reassess the resident's smoking behaviors after several non-compliance issues and implement new interventions to reduce the risk of smoking injury to himself and others. The AP assessed the resident the day prior to the fire, however the smoking assessment indicated the exact same answers as the previous assessment and failed to document and reassess the resident's non-compliance with smoking.

The resident's progress notes indicated a fire started in the resident's room and the resident did not make it out of his room despite attempts by the fire department and paramedic staff.

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 3, the resident's room. The report indicated the fire department arrived to help with the fire, and the other residents were evacuated to another facility.

A written statement from the ULP indicated she worked at the facility when the fire happened. The ULP's statement indicated she had completed cares, assisted the resident to lay down in bed, and proceeded to go to resident 2's room to assist resident 2 when she heard the smoke detector sounding. Upon inspection of the alarm sounding, the ULP statement indicated she saw fire coming out of the resident's room. The statement indicated the ULP ran to get the fire blanket while calling 911. The statement indicated the fire became too much for the ULP to enter the room, so the ULP closed other facility room doors and ran to the basement to alert an ambulatory resident of the fire.

During an interview, the AP stated the resident's smoking materials were locked in a cabinet, and he initiated room checks three times a week to ensure the resident did not have any smoking materials on him. The AP stated they did not find any smoking materials in the resident's room during the room checks.

During an interview, a registered nurse (RN) stated staff assisted the resident to go outside to smoke, and all smoking supplies were stored with the staff. The RN stated the resident would take off his oxygen, staff gave him his supplies, and the resident would light his own cigarette then called staff when he was ready to come back inside. The RN stated he had heard the resident had some previous noncompliance with the facility smoking policy, but he had not witnessed it himself. The RN stated the resident was not considered an independent smoker due to the assistance that he did need to smoke. The RN stated he believed the resident obtained cigarettes and other smoking materials from visitors he had.

During an interview, the ULP stated on the day of the fire, she was in resident 2's room assisting him when she heard the smoke detector sounding. The ULP stated when she looked to see what was going on, she saw a large fire coming out of the resident's room and could not enter the room due to the size of the fire. The ULP stated she shut the door of resident 2's room while on the phone with 911 and ran to the basement to notify an ambulatory resident downstairs of the fire. The ULP stated she exited the facility with the ambulatory resident and the fire department would not let her re-enter the facility. The ULP stated she had no idea how the fire started, and she saw no smoking materials on the resident or in his room when she had assisted him to bed just prior to the fire.

During an interview, the resident's case manager (CM) stated she attended a care meeting with the resident, herself and the AP, where they discussed with the resident the dangers of smoking

in his room. The CM stated she discussed with the resident during the meeting that smoking in his room was not safe for him or others, and it put everyone at risk for a fire, especially since he used oxygen. The CM stated the resident at first stated nothing would happen and did not see anything wrong with what he did, but the resident did eventually state that he understood and would follow the facility smoking policy. The CM stated when she checked in with the resident a month after the meeting, the AP notified her the resident had not attempted to smoke in his room since the meeting the month prior.

The resident was not interviewed due to being deceased.

Family did not return the investigators request for interview.

The resident's death record and fire report were not available at the time of the investigation.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility and the AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

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

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

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility and the AP failed to follow the facility directive and/or policies and procedures.

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

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

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, did not respond to request for interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed fire drills as required and completed room checks for smoking materials.

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
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38008	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTHCARE SOLUTIONS LLC	8119 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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 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		

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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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(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
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38008	A. BUILDING: _____ B. WING _____	C 06/10/2025

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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		

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		