STATE LICENSING COMPLIANCE REPORT

Report #: HL402847127C

Date Concluded: July 23, 2025

Name, Address, and County of Facility Investigated:
Universal Health Care Solutions
124 High Valley Road
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40284	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE SOLUTIONS LLC	124 VALLEY HIGH ROAD BURNSVILLE, MN 55337

(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: HL402847127C 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 3 residents receiving services under the provider's provisional Assisted Living license. The following correction orders are issued for HL402847127C, tag identification 470, 630.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and observation, the licensee failed to ensure staff were always onsite, 24 hours per day, seven days per week, as required for 3 of 3 residents (R1, R2, R3) 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	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnosis included chronic obstructive pulmonary disease and chronic pain. R1's service delivery record dated April 1, 2025, indicated R1 received assistance with mobility and transfers. R2's diagnosis included bipolar disorder. R2's service delivery record dated June 10, 2025, indicated R1 received assistance with safety checks and behavior management. R3's diagnosis included unspecified psychosis and pre-excitation syndrome. R3's service delivery record dated June 9, 2025, indicated R1 received assistance with toileting, mobility, and behavior management. On June 10, 2025, at 9:59 a.m., the investigator arrived at the facility and observed a white car exiting the driveway. The investigator observed R1 smoking in the garage of the facility. When the investigator knocked on the front door of the facility, the door slightly opened. The investigator entered the facility after announcing arrival and identifying self. The investigator noted there was no staff present in the facility. At 10:04 a.m., the white car returned to the driveway and a staff member, unlicensed personnel (ULP)-D, entered the facility. ULP-D confirmed there was no other staff at the facility other than him. The investigator noted three residents present at the facility. During an interview on June 24, 2025, at 12:10 p.m., licensed assisted living director (LALD)-B	0 470		

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0 470	Continued From page 3 stated there was one staff member scheduled per shift. LALD-B stated staff were to remain on site for their whole shift and were not ever permitted to leave the residents unsupervised. During an interview on July 1, 2025, at 9:07 a.m., ULP-D stated staff were not permitted for resident's to be in the facility with no staff present. ULP-D stated he had never left the facility leaving residents unattended, then stated the day the investigator was on site, he left to get medication at the gas station for a headache, but he was not permitted to do that. ULP-D stated he did not believe the residents were at risk for abuse while he was gone. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 630 SS=F	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 document review, the licensee failed to assess and develop	0 630		

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0 630	Continued From page 4 interventions for smoking vulnerabilities in an individualized abuse prevention plan (IAPP), as required for 2 of 3 residents (R1, R2) 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 the potential to affect a large portion or all of the residents). The findings include: R1's diagnosis included chronic obstructive pulmonary disease and chronic pain. R1's service delivery record dated April 1, 2025, indicated R1 received assistance with mobility and transfers. R1's assessment dated June 8, 2025, indicated R1 smoked two packs of cigarettes per day and required staff assist to get outside to smoke. The assessment indicated R1 reported smoking in the designated smoking area. R1's service delivery record dated June 10, 2025, lacked documentation of any smoking interventions performed by staff. R1'a IAPP dated July 3, 2025, lacked documentation of acknowledging R1 smoked and interventions to preserve R1 and others from any harm related to smoking. R2's diagnosis included bipolar disorder. R2's service delivery record dated June 10, 2025, indicated R1 receivesd assistance with safety checks and behavior management.	0 630		

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0 630	Continued From page 5 R2's assessment dated June 7, 2025, indicated R2 smoked two packs of cigarettes a day. The assessment indicated R2 stored his smoking materials in his personal belongings and followed the facility smoking policy. R2's service delivery record dated June 10, 2025, lacked documentation of any smoking interventions performed by staff. R2's IAPP dated June 7, 2025, lacked documentation acknowledging R2 smoked as a vulnerability. On June 10, 2025, at 9:59 a.m., the investigator observed R1 smoking inside the garage of the facility. The investigator noted there was no staff present in the facility. The investigator observed a cigarette butt disposal container approximately 20 feet in front of the garage in the driveway. During an interview on June 24, 2025, at 12:10 p.m., licensed assisted living director (LALD)-B stated a resident's IAPP should include if they smoke. LALD-B stated residents are expected to smoke in the designated smoking area. LALD-B stated R1 follows the facility smoking policy. During an interview on June 30, 2025, at 12:00 p.m., registered nurse (RN)-E stated he completes IAPP's and if a resident smokes, it is very important to include that on the IAPP. RN-E stated resident assessments should accurately reflect care needs and interventions. During an interview on July 1, 2025, at 9:07 a.m., unlicensed personnel (ULP)-D stated the designated smoking area is outside by the front of the driveway, near the front of the garage door.	0 630		

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0 630	Continued From page 6 ULP-D stated residents are not allowed to smoke anywhere else, other than the designated smoking area. ULP-D stated there were two residents who smoked, and they were both compliant with the smoking policy. The licensee-provided policy titled Smoking/Tobacco Use, dated January 15, 2025, indicated the facility is a smoke-free facility and no smoking materials will be allowed in the building. The same policy indicated residents will he allowed to smoke only as specified in their care plan. The policy indicated no smoking will be allowed in the garage. The policy indicated those deemed unsafe to smoke independently will be allowed to smoke only under direct supervision of family or facility staff. TIME PERIOD FOR CORRECTION: 7 days	0 630		