



STATE LICENSING COMPLIANCE REPORT

Report #: HL388646650C

Date Concluded: October 30, 2023

Name, Address, and County of Facility

Investigated:

Unified Health Care

6940 Zane Avenue N

Brooklyn Park, MN 55429

Hennepin County

Facility Type: Provisional Assisted Living
Facility with Dementia Care (PALFDC)

Evaluator's Name: Barbara Axness, 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.

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38864 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/30/2023 |
|--|--|---|---|

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| NAME OF PROVIDER OR SUPPLIER UNIFIED HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429 |
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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 |
|--------------------|---|---------------|---|--------------------|
| 0 000 | <p>Initial Comments</p> <p>On October 30, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL388646650C. No correction orders are issued.</p> | 0 000 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____