STATE LICENSING COMPLIANCE REPORT

Report #: HL388648972C

Date Concluded: January 25, 2024

Name, Address, and County of Facility Investigated:
Unified Health Care
6940 Zane Ave. North
Brooklyn Park, MN 55455
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brooke Anderson, 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
	38864	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

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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: #HL388648972C On January 25, 2024, 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 0 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000		

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0 000	Continued From page 1 The following correction order is issued/orders are issued for #HL388648972C tag identification _0860, 1130____.	0 000		
0 860 SS=F	144G.45 Subd. 6 New construction; plans (a) For all new licensure and construction beginning on or after August 1, 2021, the following must be provided to the commissioner: (1) architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval; (2) final architectural plans and specifications must include elevations and sections through the building showing types of construction, and must indicate dimensions and assignments of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show the location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan must indicate the proposed and existing buildings, topography, roadways, walks and utility service lines; and (3) final mechanical and electrical plans and specifications must address the complete layout	0 860		

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0 860	Continued From page 2 and type of all installations, systems, and equipment to be provided. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching, and accessories. Ventilation plans must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include the fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show location of nurse call signals, cable lines, fire alarm stations, and fire detectors and emergency lighting. (b) Unless construction is begun within one year after approval of the final working drawing and specifications, the drawings must be resubmitted for review and approval. (c) The commissioner must be notified within 30 days before completion of construction so that the commissioner can make arrangements for a final inspection by the commissioner. (d) At least one set of complete life safety plans, including changes resulting from remodeling or alterations, must be kept on file in the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to submit plans for review and approval with a planned remodel of the facility water system. The licensee notified residents of	0 860		

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0 860	Continued From page 3 the need for relocation due to the need of maintenance and remodel of the facility water system but no plans were submitted to the state department for approval and/or review. 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: During an interview on January 24, 2024, at 3:02 p.m., a community advocate agency (CAA) staff member (CAA-B) stated the licensee's director of operations (DO)-A reported water issues at the facility and expressed a need to relocate all residents of the facility due to water damage. CAA-B stated DO-A initally spoke hypothetically about relocating residents. CAA-B advised DO-A on how to conduct a relocation of residents in an emergency. CAA-B stated they never received documentation regarding the renovation. CAA-B received a list of where residents were supposed to move to but the residents were sent to the emergency room. Review of Minnesota Department of Health (MDH) documentation on January 24, 2024, indicated MDH had no record the licensee provided notification to MDH of construction to the building. On January 25, 2024, a complaint investigation was initiated by an MDH investigator. The MDH	0 860		

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0 860	Continued From page 4 investigator arrived at the licensee at approximately 1:30 p.m. The licensee's driveway had one car and one white van parked but no evidence of activity, and the facility appeared vacant. The door was locked but answered by the licensee's director of operations (DO)-A, who was in the building. The MDH investigator explained the visit was in regard to a complaint investigation. DO-A stated there were no residents or staff currently at the facility. The MDH investigator requested a tour of the building During the tour on January 25, 2024, the investigator observed level one was vacant. Belongings were noted in the lobby of level one. Level two appeared vacant and the lights were off. During the tour, DO-A indicated level three had water damage and all residents had to be emergency relocated due to the damage. DO-A indicated the facility previously had seven residents; two of the residents were relocated by their family and found new locations closer to their home and five additional residents were relocated by their case managers. Two apartments (Room 301 and Room 312) on the third floor included resident (R1, R4?) belongings. DO-A indicated R1 was relocated to a skilled nursing facility after she went to the hospital. During the tour, DO-A did not show the investigator evidence of water damage or the cause of the damage that required repair. No evidence of significant water damage was observed by the investigator. During an interview on January 25, 2024, at 1:30 p.m., DO-A stated the belongings in the lobby were R2's. DO-A stated the licensee did not have a resident roster because all residents were discharged due to water damage and the need	0 860		

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0 860	Continued From page 5 for repairs to the water system. DO-A stated the repairs were required to be done and the building was still under warranty, so the original builder was required to complete the repairs. DO-A could not provide a timeline for the intitiation or completion of construction or provide detail of what repairs were required. DO-A stated the original construction company took short cuts and water damage was coming from the roof. DO-A provided the MDH investigator with the documents requested, however, when a second request was made for additional progress notes, DO-A stated he quit paying the medical record company and no longer had access to progress notes. DO-A could not provide explanation for why he had access to the previously requested discharge progress note but no access to the additional progress notes requested by the investigator. No additional information was provided. Time Period for Correction: Twenty-One (21) Days	0 860		
01130 SS=G	144G.55 Subd. 2 Safe location A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies.	01130		

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01130	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, record review and interview, licensee failed to ensure transfer of residents to an adequate and safe location when three of three residents (R1, R2, and R3) were transferred to the hospital due to the licensee's inability to coordinate transfer of the residents to an appropriate provider. The provider planned to relocate the resident due to building maintenance needs and when attempts to coordinate transfers of the residents were unsuccessful, the residents were transferred to the hospital via emergency services. 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 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: On January 25, 2024, a complaint investigation was initiated by an MDH investigator. The MDH investigator arrived at the licensee at approximately 1:30 p.m. The licensee's driveway had one car and one white van parked but no evidence of activity, and the facility appeared vacant. The door was locked but answered by the licensee's director of operations (DO)-A, who was in the building. The MDH investigator explained the visit was in regard to a complaint investigation. DO-A stated there were no residents or staff currently at the facility. The	01130		

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01130	Continued From page 7 MDH investigator requested a tour of the building. During the tour on January 25, 2024, the investigator observed level one was vacant. Belongings were noted in the lobby of level one. Level two appeared vacant and the lights were off. During the tour, DO-A indicated level three had water damage and all residents had to be emergency relocated due to the damage. DO-A indicated the facility previously had seven residents; two of the residents were relocated by their family and found new locations closer to their home and five additional residents were relocated by their case managers. Two apartments (Room 301 and Room 312) on the third floor included resident (R1, R4?) belongings. DO-A indicated R1 was relocated to a skilled nursing facility after she went to the hospital. During the tour, DO-A did not show the investigator evidence of water damage or the cause of the damage that required repair. No evidence of significant water damage was observed by the investigator. Review of Minnesota Department of Health (MDH) documentation indicated no record of the licensee providing notification to MDH of reconstruction to the building related to water damage or any additional repairs or required remodeling of the building. A discharge roster and resident medical records including face sheets, progress notes, discharge summaries, and relocation notices were requested by the MDH investigator upon completion of the facility tour on January 25, 2024. During an interview on January 25, 2024, at 1:30	01130		

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01130	Continued From page 8 p.m., DO-A stated the belongings in the lobby were R2's. DO-A stated the licensee did not have a resident roster because all residents were discharged due to water damage and the need for repairs to the water system. DO-A stated the repairs were required to be done and the building was still under warranty, so the original builder was required to complete the repairs. DO-A could not provide a timeline for the intitiation or completion of construction or provide detail of what repairs were required. DO-A stated the original construction company took short cuts and water damage was coming from the roof. DO-A provided the MDH investigator with the documents requested, however, when a second request was made for additional progress notes, DO-A stated he quit paying the medical record company and no longer had access to progress notes. DO-A could not provide explanation for why he had access to the previously requested discharge progress note but no access to the additional progress notes requested by the investigator. R1 R1 was admitted on September 26, 2023, with diagnoses that included anxiety, major depressive disorder, and emphysema. R1 began receiving skilled nursing care from an outside agency on October 1, 2023, for maintenance of ostomies and wound care. The agency made visits to R1 at the facility to provide the wound care. R1 discharged from the agency skilled nursing care on January 5, 2024 as R1 was able to independently manage her ostomy and fistula. During an observation on January 25, 2024, R1's	01130		

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01130	Continued From page 9 room contained R1's belongings. The bed was made and R1's items were present. R1's medical record included an Emergency Temporary Relocation Notice dated January 1, 2024 but signed by R1 on December 29, 2023. The notice indicated contractors required full access to resident rooms to address flooring issues and to repair the water system. The notice indicated upon completion of repairs the resident had the right to return to the facility and services would not be terminated without the resident's consent and the resident had the right to refuse the relocation. The notice did not contain the required information of the name and address of the relocation and 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 was unknown. A facility discharge roster indicated R1 was discharged from the licensee on January 9, 2024. R1's medical record included a discharge summary dated January 4, 2024, at 10:04 p.m. (5 days prior to R1's discharge) which indicated R1's ostomy bags were intact and R1 was able to independently manage her ostomy bag care. The discharge summary indicated R1 had ongoing abdominal pain and had prescribed narcotic medication for pain management. The discharge summary included no information on the reason for discharge, location of discharge, time of discharge, or that an emergency relocation notice was provided. During an interview on January 24, 2024, at 3:02 p.m., a community advocate agency (CAA) staff member (CAA-B) stated the licensee's director of	01130		

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01130	Continued From page 10 operations (DO)-A reported water issues at the facility and expressed a need to relocate all residents of the facility due to water damage. CAA-B stated DO-A initally spoke hypothetically about relocating residents. CAA-B advised DO-A on how to conduct a relocation of residents in an emergency. CAA-B stated they never received documentation regarding the renovation. CAA-B received a list of where residents were supposed to move to but the residents were sent to the emergency room. CAA-B provided emails to the MDH investigator which included that on December 27, 2023, CAA-B was notified DO-A was trying to move all residents to a neighboring facility, without conducting necessary relocation responsibilities under 144G (assisted living) statutes. Upon learning of this information CAA-B held a meeting at the facility on December 27, 2023, where CAA-B met with the residents about their rights and proposed transfers. During an interview on January 25, at 1:30 p.m., DO-A stated R1's belongings were all still in her room. R1 had been relocated to a long-term care facility. DO-A stated R1 did not go to the hospital for medical reasons but said she did have some problems with her ostomy. DO-A denied a plan for R1 to get her belongings and stated R1 could return once the building was repaired. Hospital records indicated R1 was tranferred from the facility to the emergency room on January 9, 2024. Hospital records indicated the resident was admitted to the emergency room for pain management and decreased ostomy output. R1 was tearful when discussing discharge planning and her situation. R1's hospital records indicated DO-A stated the facility was a "risk hazard" and it	01130		

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01130	Continued From page 11 was "not safe" for R1 to return. R1 reported her belongings are still at the facility. In the hospital record, R1 reported she received services from a home health care agency for ostomy care, but the service stopped one week prior to going to the hospital. During an interview with R1's case manager (CM-C) on January 29, 2024, at 11:37 a.m., CM-C indicated she took over as R1's case manager on Monday, January 8, 2024, and was told R1 needed to move out of the facility by Tuesday, January 9, 2024. CM-C indicated she tried to get a hold of DO-A and he didn't answer. CM-C stated she spoke with DO-A on Tuesday who said R1 had to move on Wednesday because they were going to start fixing the building. CM-C stated at first she was told the repairs would take two to three weeks and then it was 5-6 weeks. The facility didn't even know what the specific water damage was, and when asked, they could not provide specifics on what was wrong. DO-A called CM-C and said the placement location needed documentation. CM-C called DO-A and asked him if he got the paperwork done. DO-A said "No, not yet, and DO-A had also not called to get approval from the doctor. CM-C stated DO-A had the documents for a week but didn't fill out the documents or ask for help. [R1] was in tears, she didn't want to leave. CM-C stated DO-A was advised that it was his responsibility to find placement for R1. The ombudsman called and asked if there was a new place approved. R1 was crying because she didn't know where the new placement was and she was so upset and they ended up hospital dumping her [R1]. My co-worker then received an email stating the facility was taking admissions! R1 is really stressed; she doesn't want to look at other places. CM-C indicated she has not been in	01130		

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01130	Continued From page 12 contact with DO-A since R1's hopsital admission and DO-A had not contacted R1 to attempt to coordinate for R1 to obtain her belongings. CM-C indicated R1 was upset about the relocation and did not want to move. CM-C indicated immediate placement could not be found at the time of R1's hospital discharge and R1 was staying with a family member before availability opened up at another location. R2: R2 admitted on November 15, 2023, with diagnoses that included congestive heart failure, myocardial infarction, diabetes and paranoid schizophrenia. R1 also received services from an outside home health care agency for skilled nursing care on December 14, 2023, for maintenance of indwelling catheter. R2's room was observed. R2's belongings were boxed up and observed in the lobby. R2's record included an Emergency Temporary Relocation Notice dated January 1, 2024, lacked evidence of an address R2 was to be relocated to and the length of the relocation. R2's Emergency Temporary Relocation Notice lacked R2's signature acknowledging the relocation. R2's skilled nursing record dated January 4, 2024, indicated R2 was at baseline, urine was light yellow and clear. Skilled nursing notes indicated R2 would need extended skilled nursing for ongoing catheter management. R2's skilled nursing record dated January 11, 2024, indicated R2 was sent to the hospital on	01130		

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01130	Continued From page 13 January 5, 2024. A facility discharge roster indicated R2 was discharged January 5, 2024. R2's progress notes dated January 4, 2024, 11:00 p.m. included a discharge summary. R2's discharge summary was created prior to R2 being sent to the hospital on January 5, 2024 and lacked a service termination notice. During an interview on January 25, 2024, at 1:30 p.m., DO-A stated R2 was admitted to the hospital for a urinary tract infection. R3: R3 was admitted on December 12, 2023, with diagnoses that included quadriplegia. R3's room was observed. R3's belongings were boxed up and present in the room. R3's Emergency Temporary Relocation Notice effective January 1, 2024, lacked evidence of an address R3 was to be relocated to and the length of the relocation. R3's Emergency Temporary Relocation Notice lacked a date with R3's signature. Facility discharge roster indicated R3 was discharged January 4, 2024. R3's progress notes dated January 4, 2024, 10:30 p.m. included a discharge summary. R3's discharge summary lacked service termination notice. During an interview on January 25, 2024, at 1:30am, DO-A stated R3 was admitted to the	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38864	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

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01130	Continued From page 14 hospital for blood in his colostomy bag. During an interview on January 25, 2024, DO-A stated the licensee had no residents living in the building and currently no staff. DO-A stated all residents were relocated due to facility damages. DO-A stated the licensee did not have a resident roster because all of the residents were discharged. DO-A stated he could provide a discharge roster. DO-A stated he could not obtain additional resident medical records because the licensee stopped paying for the charting service and they no longer have access. DO-A stated there was not a timeline for the construction to be completed. DO-A stated the licensee was waiting on the builder because the building was still under warranty. DO-A stated all the residents could return when asked why all the residents' belongings were still present. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01130		