



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 9, 2025

Licensee
Amy Johnson Residence
89 Virginia Street
Saint Paul, MN 55102

RE: Project Number(s) SL30229016

Dear Licensee:

On August 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 21, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Renee L. Anderson'.

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/07/2025
NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
(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 FOLLOW UP SURVEY INITIAL COMMENTS SL30229016-1 On August 6, 2025, to August 7, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 21, 2025. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living license. As a result of the follow-up survey, the licensee is in substantial compliance.	{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.		
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by:	{0 340}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	{0 470}	Not reviewed during this follow up survey.		

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{0 470}	Continued From page 2 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:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	{0 480}	Not reviewed during this follow up survey.		

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{0 480}	Continued From page 3 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be	{0 480}			

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STATE FORM

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{0 660}	Continued From page 5 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this follow up survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	{0 680}			

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{0 680}	Continued From page 6 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this follow up survey.		
{0 790} SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	{0 810}			

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{0 810}	Continued From page 7 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personnn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	{01370}	Not reviewed during this follow up survey.		

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{01370}	Continued From page 8 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	{01380}	Not reviewed during this follow up survey.		

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{01380}	Continued From page 9 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this follow up survey.		
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	{01440}			

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{01440}	Continued From page 10 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this follow up survey.		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	{01470}			

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{01470}	Continued From page 11 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01470}	Not reviewed during this follow up survey.		

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{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	{01500}			

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{01500}	Continued From page 13 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this follow up survey.		
{01530} SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	{01530}			

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{01530}	Continued From page 14 (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}			
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	{01640}	Not reviewed during this follow up survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/07/2025
NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
(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	
{01640}	Continued From page 15 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this follow up survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 24, 2025

Licensee

Amy Johnson Residence
89 Virginia Street
Saint Paul, MN 55102

RE: Project Number(s) SL30229016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

Amy Johnson Residence

July 24, 2025

Page 3

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Renee L. Anderson". The ink is dark and the signature is fluid.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: Renee.L.Anderson@state.mn.us Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102			
(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30229016-0 On May 19, 2025, through May 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 residents, 18 residents receiving services under the Assisted Living Facility license. An immediate correction order was issued May 19, 2025, for SL30229016-0 correction tag 1290.	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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed July 12, 2022. The lack of action to ensure compliance with regulations had the potential to affect 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) and was issued at a widespread scope (when problems are pervasive	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The result of the licensee's previous survey, concluded on July 12, 2022, was sent to the licensee via email on August 10, 2022. The result communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or August 31, 2022. The licensee's plans of correction (POC) from survey dated July 12, 2022, lacked a documented plan of correction for the following orders: -0580, 144G.42 Subd. 2. Quality management; -0680, 144G.42 Subd. 10. Disaster planning and emergency preparedness plan; and -1530, 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-escalation required. The above-listed correction orders were reissued as a result of the current survey, ending May 21, 2025. On May 21, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated she was not employed with licensee for the previous survey and she planned to follow up this survey, and ensure these orders were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

Minnesota Department of Health

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0 470	Continued From page 3	0 470			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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 record review, the licensee failed to develop and implement a staffing plan, reviewed at least twice a year, to determine staffing levels to meet the needs of all residents, potentially affecting all the licensee's current residents, staff, and visitors.	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 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 the residents). The findings include: On March 19, 2025, at 12:08 p.m., after the entrance conference, the surveyor requested a copy of the licensee's most current staffing plan review and staffing plan policy. On March 20, 2025, at 11:12 a.m., licensed assisted living director (LALD)-A stated the team discussed staffing routinely, and reviewed the work schedule monthly but did not have documentation of a staffing plan, other than the monthly work schedule. The licensee's May 2025 Work Schedule lacked evidence the following were considered in determining staffing levels: -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	0 470			

Minnesota Department of Health

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0 470	Continued From page 5 in the facility. On March 20, 2025, at 12:30 p.m., LALD-A stated she was not able to find a documented review of the staffing plan with the required content. LALD-A was unaware of the requirement to review the staffing plan at least twice yearly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or	0 480			

Minnesota Department of Health

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0 480	Continued From page 6 tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 20, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 580			

Minnesota Department of Health

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0 580	Continued From page 8 licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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) 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: On May 19, 2025, at 12:08 p.m., after the entrance conference, the surveyor requested, via email, to review the licensee's quality management plan. On May 19, 2025, at 2:04 p.m., the surveyor requested a second time, via email, the licensee's quality management policy. On May 21, 2025, at 12:25 p.m., licensed assisted living director (LALD)-A stated she had not created a quality management program or documented a quality management meeting for the program yet. LALD-A verbalized they continuously verbally talk about quality management topics but do not have anything documented. LALD-A verbalized she planned to get a quality management program and meeting documented. The quality management policy was not provided. No further information provided.	0 580			

Minnesota Department of Health

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0 580	Continued From page 9	0 580			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, and baseline TB testing for one of three employees (clinical nurse supervisor (CNS)-B). 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	0 660			

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NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102			
(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
0 660	Continued From page 10 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: During the entrance conference on May 19, 2025, at 11:40 a.m., the surveyor requested to review the licensee's TB facility risk assessment. Licensed assisted living director (LALD)-A stated she would provide the risk assessment, if able to locate the form. CNS-B was hired February 15, 2025, and provided direct nursing cares and services to residents. CNS-B's employee record included a negative QuantiFERON-TB Gold blood test completed on September 23, 2024, more than 90 days prior to hire date. On May 19, 2025, at 1:35 p.m., CNS-B stated she did not have a TB test completed within 90 days of her hire date. CNS-B verbalized she was not aware of this requirement but planned to get an updated TB blood test completed. On May 19, 2025, at 2:04 p.m., the surveyor requested, via email, a copy of the licensee's TB prevention policy. The policy was not provided. On May 20, 2025, at 9:20 a.m., LALD-A provided a completed facility TB risk worksheet dated May 19, 2025, completed during the survey. LALD-A verbalized she was not aware the risk assessment must be completed annually. The Minnesota Department of Health (MDH)	0 660			

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0 660	Continued From page 11 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. In addition, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the healthcare worker (HCW) starts working with patients." The MDH Assisted Living Resources and Frequently Asked Questions website updated December 13, 2024, included under Tuberculosis Screening, "Each facility must establish and maintain a comprehensive TB infection control program according to the most current tuberculosis infection control guidelines issued by the United States CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers." Also, indicated "Each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening."	0 660			

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0 660	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to have a written emergency	0 680			

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0 680	Continued From page 13 disaster preparedness plan with all the required content and a hazard vulnerability assessment (HVA). This had the potential to affect 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) 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: On May 21, 2025, licensed assisted living director (LALD)-A stated some of the emergency preparedness plan (EPP) documents were located in the main floor kitchen area and some are stored in the basement in the maintenance room. LALD-A provided the surveyor with the licensees EPP binder. The licensee's Emergency and Disaster Preparedness binder dated April 2025, lacked the following required content: -a risk assessment to include hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; -development of a communication plan; -a system to track the location of on-duty staff and sheltered residents; -a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -to address role of facility under a waiver declared	0 680			

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0 680	Continued From page 14 by the Secretary in accordance with section 1135 of the Act; -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; -policies and procedures for medical documents; and -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On May 21, 2025, at 12:24 p.m., LALD-A stated she was responsible for the EPP for the licensee. LALD-A stated she had not had the opportunity to create all facility-specific emergency plans with the required content identified in Appendix Z. The licensee's undated Plan of Emergency Procedures indicated, "1. Identify at least two escape routes: one the front exit door, second the side exit door and third the back exit door. 2. Identify the evacuation plan for persons with disabilities who will need assistance to evacuate safely: Staff will assist persons requiring help in evacuating. 3. Fire Extinguisher Locations: In the kitchen, Maintenance room, 2nd floor hallway, at resident desk, one on 3rd floor near Administrator's office. 4. Smoke Detector Locations: Located in each resident room, in the laundry room and in each 3rd floor office. 5. Designated place to meet outdoors for fire drills: Meet out in front of Amy Johnson Residence on the sidewalk. Med Room Staff will have the sign out book and/or a laptop to do a head count and account for all residents. Designated place to	0 680			

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0 680	Continued From page 15 meet in case of storm or tornado: Residents will shelter in the basement Maintenance Room. Those who are unable to do downstairs will sit in the first floor hallway on chairs. Residents will be instructed to grab their bed pillows and take with them to cover their heads." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 790			

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0 790	Continued From page 16 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 the residents). The findings include: On May 21, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A and maintenance worker (M)-I. The following was observed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Portable fire extinguishers must be provided with monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810			

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0 810	Continued From page 17 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect 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) and was issued at a widespread scope (when problems are pervasive	0 810			

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0 810	Continued From page 18 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 21, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 19 The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the FSEP. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on March 24, 2025, and April 24, 2025. No other documentation was provided. On May 21, 2025, LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil	01290			

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01290	Continued From page 20 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study affiliated with the licensee's health facility identification number (HFID), upon hire, and prior to providing services for three of three employees (maintenance (M)-G, cook (C)-H, and unlicensed personnel (ULP)-F). 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 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: The licensee's HFID was 30229 and the licensee provided assisted living services beginning August 1, 2021. M-G and C-H On May 19, 2025, at 10:25 a.m., the surveyor observed M-G walking through the hallways of the facility in direct contact with the licensee's residents. M-G was hired October 6, 2020, and respectively, and provided maintenance services to the licensee's residents.	01290	The licensee took initial steps to mitigate the immediate risk, however failed to submit an acceptable plan of correction at the time of survey exit; the scope and severity remained at level 3, widespread.		

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01290	Continued From page 21 C-H was hired October 30, 2024, and provided food preparation services for residents. M-G and C-H's employee records lacked evidence of a cleared DHS background study completed upon hire. ULP-F ULP-F was hired on May 8, 2025, and provided direct care services to the licensee's residents. The licensee's May 2025 Work Schedule indicated ULP-F worked the following shifts: -May 10, 2025, from 3:30 p.m., to 7:30 p.m.; and -May 11, 2025, from 7:30 a.m., to 2:00 p.m., and 3:30 p.m., to 7:30 p.m. ULP-F's employee record included a cleared background study that was affiliated with HFID 34772, a staffing agency. The record lacked evidence of a cleared background study affiliated with the licensee's HFID on the DHS Net Study 2.0 Roster at the time of survey initiation. On May 19, 2025, at 2:10 p.m., office manager (OM)-C stated M-G, C-H and ULP-F were currently providing services to the licensee's residents. OM-C verbalized M-G provided maintenance, cleaning, and resident interactions. OM-C stated C-H worked in the kitchen area and provided food preparation assistance for the licensee's residents. OM-C further stated ULP-F had been working for the licensee through a staffing agency, but as of May 8, 2025, was permanently employed with the licensee. On May 19, 2025, at 2:38 p.m., licensed assisted living director (LALD)-A stated ULP-F currently worked for both the licensee and the staffing agency. LALD-A further stated they did not have a	01290			

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01290	Continued From page 22 cleared background study for ULP-F, affiliated with the licensee's HFID (30229). On May 19, 2025, at 3:04 p.m., OM-C stated a background study was not completed for M-G, and C-H. OM-C further verbalized she realized ULP-F's background study was currently not affiliated to the licensee's HFID (30229). The licensee's Background Study Privacy Notice dated December 2006, indicated, "1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS.	01290			

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01290	Continued From page 23 County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving	01370			

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NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
(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
01370	Continued From page 24 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed with all required content for one of two employees (unlicensed personnel (ULP)-E). 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) 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 May 19, 2025, at 11:40 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated initial training, and competency was provided by the licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed both in person and utilizing an online training program. ULP-E was hired on March 11, 2025, to provide	01370			

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01370	Continued From page 25 direct care services to residents of the assisted living facility. On May 20, 2025, from 7:43 a.m., until 8:11 a.m., the surveyor observed ULP-E assist residents with cares including a blood pressure check, oxygen tubing change, and assistance with medication administration. ULP-E's employee record lacked documentation of training and competency evaluations including: -reports of changes in the resident's condition to the supervisor designated by the facility; -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. On May 21, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the training and competency items in ULP-E's employee record were not found, so they were not completed. The licensee's In-Service Training policy dated June 2021, indicated, "1. All unlicensed staff performing Assisted Living Home Care services	01370			

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01370	Continued From page 26 will complete a minimum of 8 hours of in-service training for each 12 months of employment. In--service training will include, but will not be limited to, the following topics: -Infection control [this is mandatory every 12 months of employment for both licensed and unlicensed staff]; -Home care bill of rights; -Vulnerable Adult Act; -Handling emergencies; -Building fire/disaster plan; -Nutrition; -Common health problems in seniors (diabetes, hypertension, etc.); -AWAIR plan; -Memory loss. 2. For each 12 months of employment, all Assisted Living Home Care staff, including RN/Clinical Nurse Supervisors, LPNs and other management staff, must have annual infection control in-service training. This training must include: -Hand washing techniques; -The need for and use of protective gloves, gowns, and masks; -Disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; -Disinfecting reusable equipment; and -Disinfecting environmental surfaces. 3. Documentation of satisfying the above in-service training requirement will be retained for each employee performing Assisted Living Home Care services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 27	01380			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluation was completed with all required content for one of two employees (unlicensed personnel (ULP)-E). 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) 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:	01380			

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01380	Continued From page 28 On May 19, 2025, at 11:40 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated initial training, and competency was provided by the licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed both in person and utilizing an online training program. ULP-E was hired on March 11, 2025, to provide direct care services to residents of the assisted living facility. On May 20, 2025, at 7:43 a.m., until 8:11 a.m., the surveyor observed ULP-E assist residents with cares including a blood pressure check, oxygen tubing change, and assistance with medication administration. ULP-E's employee record lacked documentation of training and competency evaluations for ULPs providing assisted living services, including: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On May 21, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the training and competency items in ULP-E's employee record were not found, so they were not completed. The licensee's Competency Evaluations of Unlicensed Staff policy dated July 1, 2021, indicated "1. A Registered Nurse/Clinical Nurse Supervisor will complete and document	01380			

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01380	Continued From page 29 competency of unlicensed personnel prior to their delivery of services to a resident. 2. Staff must demonstrate competency by successfully completing: -A written, oral or practical test of the topics listed under "Core Training" (MN Rules Part 4668.0840, subpart 3) -A written, oral or practical test of all Assisted Living Home Care services that the person will perform." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440			

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01440	Continued From page 30 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two employees (unlicensed personnel (ULP)-E). 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) 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: ULP-E was hired on March 11, 2025, to provide direct care services to residents of the assisted living facility. On May 20, 2025, at 7:43 a.m., until 8:11 a.m., the surveyor observed ULP-E assist residents with cares including a blood pressure check, oxygen tubing change, and assistance with medication administration. ULP-E's employee records lacked documentation of a 30-day supervision of a delegated nursing task to include observation of the staff administering the medication or treatment and the interaction with the resident.	01440			

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01440	Continued From page 31 On May 20, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-B stated the 30-day supervision of a delegated task was not completed for ULP-E, and CNS-B was not aware of the 30-day supervision requirement of a delegated task. CNS-B verbalized she would ensure this is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470			

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01470	Continued From page 32 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content	01470			

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01470	Continued From page 33 for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, ULP-E). 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: CNS-B CNS-B was hired February 12, 2025, to provide direct nursing services to residents of the assisted living facility. CNS-B's employee record lacked documentation CNS-B completed the following orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470			

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01470	Continued From page 34 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-D ULP-D was hired on July 16, 2020, to provide direct care services to residents of the assisted living facility. On May 19, 2025, at 11:10 a.m., the surveyor observed ULP-D assist R3 with medication administration. ULP-D's employee record lacked documentation ULP-D completed the following orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-E ULP-E was hired on March 11, 2025, to provide direct care services to residents of the assisted living facility. On May 20, 2025, at 7:43 a.m., the surveyor observed ULP-D assist R2 with a blood pressure check and medication administration. ULP-E's employee record lacked documentation ULP-E completed the following orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; and	01470			

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01470	Continued From page 35 -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On May 21, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated if there was not documentation of the required initial orientation in the CNS's records, or ULP-D and ULP-E's records then it was not completed. CNS-B was not able to find evidence the required topics were completed. CNS-B stated there were some required courses that would need to be assigned to all employees on the licensee's online education platform. The licensee's Core Training of Unlicensed Personnel policy dated June 2021, indicated, "Unlicensed personnel must successfully complete training or demonstrate competency in the following topics: 1. An overview of Minnesota Statutes 144A.43 to 144A.48 in regards to Home Care and Hospice Program Licensure. 2. Recognizing and handling emergencies, and using emergency services. Facility's emergency/911 procedure. 3. Reporting maltreatment of vulnerable adults or minors under the Vulnerable Adult Act. 4. The Home Care Bill of Rights. 5. Handling and reporting resident complaints. Facility Complaint Policy. 6. The services of the ombudsman for older Americans. 7. Communication skills. 8. Observing, reporting and documenting client status and the care or services provided. 9. Basic infection control. 10. Maintaining a clean and safe environment. 11. Basic elements of body functioning and changes in body function that must be reported to	01470			

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01470	Continued From page 36 the RN/Clinical Nurse Supervisor. 12. Physical, emotional and development needs of residents and ways to work with residents who have problems in those areas, including respect for the resident, his/her property and the resident's family." The licensee lacked an orientation policy that included the requirements of 144G Assisted Living laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500			

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NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
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01500	Continued From page 37 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training including required content, for each 12 months of	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
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01500	Continued From page 38 employment for one of three employees (unlicensed personnel (ULP)-D). 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) 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: ULP-D was hired on July 16, 2020, and provided direct cares for residents. On May 19, 2025, at 11:10 a.m., the surveyor observed ULP-D assist R3 with medication administration. ULP-D's employee record indicated annual training was completed on April 11, 2024. ULP-D's employee record lacked documentation of the number of hours of annual training completed within the last 12 months, and lacked documentation the following required topics were completed: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER AMY JOHNSON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 89 VIRGINIA STREET SAINT PAUL, MN 55102		
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01500	Continued From page 39 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; and -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On May 21, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated if there was no documentation of the required annual training in ULP-D's record then it was not completed. CNS-B stated there were some required courses that would need to be assigned to all employees on the licensee's online education platform. The licensee's In-Service Training policy dated June 2021, indicated, "1. All unlicensed staff performing Assisted Living Home Care services will complete a minimum of 8 hours of in-service training for each 12 months of employment. In--service training will include, but will not be limited to, the following topics: -Infection control [this is mandatory every 12 months of employment for both licensed and unlicensed staff]; -Home care bill of rights; -Vulnerable Adult Act; -Handling emergencies; -Building fire/disaster plan; -Nutrition; -Common health problems in seniors (diabetes, hypertension, etc.); -AWAIR plan; -Memory loss. 2. For each 12 months of employment, all Assisted Living Home Care staff, including RN/Clinical Nurse Supervisors, LPNs and other management staff, must have annual infection control in-service training. This training must	01500			

Minnesota Department of Health

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01500	Continued From page 40 include: -Hand washing techniques; -The need for and use of protective gloves, gowns, and masks; -Disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; -Disinfecting reusable equipment; and -Disinfecting environmental surfaces. 3. Documentation of satisfying the above in-service training requirement will be retained for each employee performing Assisted Living Home Care services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics	01530			

Minnesota Department of Health

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01530	Continued From page 41 specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training within 160 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-D, ULP-E). 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
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01530	Continued From page 42 occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on July 16, 2020, to provide direct care services to residents of the assisted living facility. On May 19, 2025, at 11:10 a.m., the surveyor observed ULP-D assist R3 with medication administration. ULP-D's employee record included 7.25 hours of dementia training. The employee record lacked evidence ULP-D completed the required eight hours of dementia training within 160 hours of employment start date. ULP-E ULP-E was hired on March 11, 2025, to provide direct care services to residents of the assisted living facility. On May 20, 2025, at 7:43 a.m., the surveyor observed ULP-E assist R2 with a blood pressure check and medication administration. ULP-E's employee record included 5.5 hours of dementia training. The employee record lacked evidence ULP-E completed the required eight hours of dementia training within 160 hours of employment start date. On May 21, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated there was no additional documented dementia training for ULP-D and ULP-E. CNS-B agreed ULP-D and ULP-E did not have the full eight hours of	01530			

Minnesota Department of Health

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01530	Continued From page 43 dementia care training completed within the required time frame of 160 hours on their training transcripts or in the employee records. CNS-B verbalized additional dementia training would be assigned for ULP-D and ULP-E. The licensee's Dementia Care Training policy dated August 1, 2021, indicated, "Direct-care employees must complete at least eight hours of initial training within 160 working hours of the employment start date, and at least two hours of training on topics related to dementia for each 12 months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640			

Minnesota Department of Health

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01640	Continued From page 44 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a service plan had been signed or authenticated by the facility representative and by the resident, or the resident's representative, to document agreement on services to be provided, for two of two residents (R2, R3). 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 19, 2025, at 11:40 a.m., during the entrance conference, the licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B verbalized they were unsure if they utilized a service plan with the required content. LALD-A stated she believed the licensee used the waiver care plan for services to be delivered. R2 R2 was admitted on December 27, 2001, and had diagnoses including schizophrenia (mental health disease), anemia (low red blood cell count), and	01640			

Minnesota Department of Health

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01640	Continued From page 45 anterior base membrane dystrophy (an eye condition). On May 20, 2025, at 7:43 a.m., the surveyor observed ULP-E assist R2 with a blood pressure check and medication administration. R2's medical record included a document titled Service Recap Summary - Month dated May 2025. The document indicated R2 received services including assistance with housekeeping, laundry, meals, activities of daily living (ADLs), bathing, toileting, safety checks, behavior management, and medication administration. R3 R3 was admitted on June 8, 2004, and had diagnoses including schizophrenia, paranoid type, and hypertension (high blood pressure). R3's medical record included a document titled Service Recap Summary - Month dated May 2025. The document indicated R3 received services including assistance with housekeeping, laundry, meals, ADLs, bathing, safety checks, behavior management, and medication administration. R2 and R3's medical records lacked a service plan with a signature or other authentication by the facility and by the resident or their representative, documenting agreement on the services to be provided. On May 21, 2025, at 9:45 a.m., CNS-B stated she was not aware of all the service plan content and authentication to be completed by the resident or the resident's representative. CNS-B stated she planned to begin using the Service Plan (Waiver) - Addendum to Contract documents for all the	01640			

Minnesota Department of Health

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01640	Continued From page 46 licensee's residents and would ensure they were authenticated, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Amy Johnson Residence
89 Virginia Street
St Paul, MN 55102
Ramsey County
Parcel:

Phone:

License Info

License: HFID 30229

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1050251019
Inspection Type: Full - Single
Date: 5/20/2025 Time: 11:30:18 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: ESTABLISHMENT MISSING MN CFPM CERTIFICATE AT TIME OF INSPECTION. OPERATOR LEAH HAS A CERTIFIED FOOD PROTECTION MANAGER THROUGH A THIRD PARTY. LICENSE NUMBER 3119431 EXPIRATION 9/1/24-9/1/29.

DISCUSSED ONLINE APPLICATION AND LINK GIVEN VIA EMAIL.

Comply By: 6/20/2025 Originally Issued On: 5/20/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED EGGS STORED OVER RTE FOODS IN REACH-N COOLER. DISCUSSED REMOVING AND SEPARATING RAW FOODS. COMPLY WITH RULE ABOVE.

OPERATOR REMOVED AND SEPARATED ON SITE 5/20/25.

Comply By: 5/20/2025 Originally Issued On: 5/20/2025

New Order: 4-200 Equipment Design and Construction

4-204.112E *Priority Level: Priority 2 CFP#: 47*

MN Rule 4626.0620E Provide food and water temperature measuring devices that are numerically scaled in increments no greater than 2 degrees F.

COMMENT: OBSERVED REACH-IN COOLER IN ESTABLISHMENT KITCHEN MISSING SECONDARY THERMOMETER INSIDE. DISCUSSED IMPORTANCE OF HAVING IN CASE OF REFER FAILURE TO ASSIST IN RECORDING AMBIENT TEMPERATURE. COMPLY WITH RULE ABOVE.

Comply By: 5/20/2025 Originally Issued On: 5/20/2025

Food & Beverage General Comment

Announced inspection completed by MDH Andrew Spaulding and Leah Abbas on 5/20/25.

Discussed pest control, food handling procedures, temperatures, leftovers, vendor deliveries, illness policy and storing procedures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1050251019 from 5/20/2025

Andrew V. Spaulding

Leah Abbas
Operator

Andrew Spaulding,
Public Health Sanitarian 2
651-201-5298
andrew.spaulding@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Amy Johnson Residence
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1050251019
Inspection Type: Full
Date: 5/20/2025
Time: 11:30:18 AM

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Watermelon; **Temperature Process:** Cold-Holding

Location: Refrigerator at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Bacon; **Temperature Process:** Cold-Holding

Location: Refrigerator at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Ham; **Temperature Process:** Cold-Holding

Location: Refrigerator at 38 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Amy Johnson Residence
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1050251019
Inspection Type: Full
Date: 5/20/2025
Time: 11:30:18 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 180 Degrees F.

Comment:

Violation Issued?: No