Electronically Delivered

November 14, 2025

Licensee
Dr Thomas H Johnson HWS
5515 Penn Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL21508016

Dear Licensee:

On November 10, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 8, 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Electronically Delivered

October 1, 2025

Licensee
DR THOMAS H JOHNSON HWS
5515 Penn Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL21508016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 8, 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. 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 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21508	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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: SL21508016-0 On August 4, 2025, through August 8, 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 five residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on August 4, 2025, issued for SL21508016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on August 7, 2025, issued for SL21508016-0, tag	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

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0 000	Continued From page 1 identification 1760. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC). 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	0 550		

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0 550	Continued From page 2 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 August 4, 2025, at approximately 11:15 a.m., during the facility tour, the surveyor observed contact information for the Minnesota Adult Abuse Reporting Center (MAARC), Office of Ombudsman for Long Term Care (OOLTC), and Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) posted on a bulletin board by the dining room on the main floor. The surveyor observed the licensee lacked the following postings: - OHFC. On August 4, 2025, at 11:39 a.m., clinical nurse supervisor (CNS)-C stated they were not aware of the requirement to post the OHFC contact information. The licensee's 2.10 Complaint/ Grievance Posting Policy dated January 31, 2023, read, "POLICY: [the licensee's name] will listen and respond to concerns and grievances of our residents. Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. [The licensee's name] will not retaliate as a result of a good faith complaint or an indication of intention to file a good faith complaint. PROCEDURE: 1. [The licensee's name] will post, in a conspicuous place, information about our	0 550		

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0 550	Continued From page 3 complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. a. OFFICE OF OMBUDSMAN FOR LONG-TERM CARE PO Box 64971 St. Paul, MN 55164-0971 1-800-657-3591 or 651-431-2555 Email: MBA.OOLTC@state.mn.us http://www.mnaging.org/Advocate/OLTC.aspx b. OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East Metro Square Building St. Paul, MN 55101-2117 1-800-657-3506 or 651-757-1800 Email: Ombudsman.mhdd@state.mn.us https://mn.gov/omhdd/ 3. In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center a. MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC) Phone: 1-844-880-1574 For more information: https://mn.gov/dhs/adult-protection/ " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 4 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, R2). 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 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 August 4, 2025, at approximately 10:45 a.m., during entrance interview clinical nurse supervisor (CNS)-C stated the provider was familiar with the current minimum assisted living requirements. R1	0 630		

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0 630	Continued From page 5 R1 was admitted to the licensee on August 29, 2018, and received assisted living services. R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, grooming, bathing, medication assist, clothing assist, catheter care, and behavior management. R1's IAPP completed on July 30, 2025, read "Resident is at risk to abuse other vulnerable adults - specify measures to minimize risk: Staff to monitor for signs or symptoms of abuse or neglect from others and report to nurse promptly." R1's IAPP identified R1 was at risk to abuse other vulnerable adults. However, R1's statements of specific measures to reduce the risk revolved around other's abusing R1. R1's IAPP lacked specific measures that pertained to R1's potential to abuse other vulnerable adults. On August 6, 2025, at 4:45 p.m., via email correspondence, clinical nurse supervisor (CNS)-C indicated, "[R1] is not currently identified as being at risk to abuse other vulnerable adults. The language in his IAPP referring to monitoring for signs or symptoms of abuse or neglect is a standard precaution applied for general resident safety. However, if it would improve clarity, we are open to revising the IAPP to clearly indicate that [R1] is not identified as a risk to others, and that no risk-specific interventions are required at this time." R2 R2 was admitted to the licensee on August 6, 2007, and received assisted living services.	0 630		

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0 630	Continued From page 6 R2's signed service plan dated January 29, 2022, indicated R2 received assistance with behavior management, diet, grooming, meal assistance, medication assistance, record vital signs, safety checks, and shopping assistance. R2's IAPP completed on August 20, 2025, indicated R2 was at risk to be abused and the specific measure to minimize the risk. The IAPP did not specify whether or not R2 was at risk to abuse others. On August 6, 2025, at 4:45 p.m., via email correspondence, CNS-C indicated, "[R2] has not demonstrated behaviors suggesting a risk of abusing other vulnerable adults. As such, no abuse prevention interventions specific to that concern have been included. If helpful, the IAPP can be updated to explicitly state that [R2] is not identified as a risk to abuse others." The Licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2021, read, "POLICY: [the licensee's name] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The abuse prevention plan for those residents who do not receive any assisted living services may be very limited given the lack of information the facility knows about such "lease-only" individuals. PROCEDURE: 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable	0 630		

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0 630	Continued From page 7 adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2. For purposes of the abuse prevention plan, abuse includes self-abuse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 775		

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0 775	Continued From page 8 On August 6, 2025, from approximately 10:25 a.m. to 12:40 p.m., the surveyor toured the facility with unlicensed person (ULP)-A, licensed assisted living director (LALD)-D and maintenance (M)-G. During the tour the surveyor observed the following: An extension cord was in use in resident room 1. Extension cords are not rated for continuous use and may pose risk of fire. Extension cords should not be used in lieu of permanent wiring. A chain lock was installed on the egress side of the front door on the 5517 side of the facility. This chain lock was installed above the allowable height to be readily openable to allow exiting in an emergency and required special effort or tools to unlock. The lock should be removed from its current location. Resident room 5 had a hasp lock installed on the exterior of the room door. This type of lock is not permitted and could lead to an obstruction of an egress path from the room. The supplied egress ladder in the window well of resident room 5 was broken and damaged making it difficult to climb. Egress features and components should be maintained in safe and operable condition. An accumulation of lint was present behind the dryer in the downstairs laundry room. Accumulated lint can be combustible and increases risk of fire. Lint should be cleaned and the dryer ventilation checked to prevent any further buildup of lint. A space heater was present in resident room 9.	0 775		

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0 775	Continued From page 9 Space heaters are not permitted in resident rooms and increase risk of fire. The supplied space heater should be removed. A multiplug adapter was in use to power a microwave in the lower-level kitchenette area. The multiplug adapter is not rated and poses risk of fire and should be removed. Several cigarette butts were present on the paved parking spaces next to the detached garage in the rear yard. Cigarettes must be properly disposed of in approved receptacles. M-G and LALD-D acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780		

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0 780	Continued From page 10 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2025, from approximately 10:25 a.m. to 12:40 p.m., the surveyor toured the facility with unlicensed person (ULP)-A, licensed assisted living director (LALD)-D and maintenance (M)-G. During the tour the surveyor observed the following:	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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
0 780	Continued From page 11 Smoke alarms were tested for interconnection by M-G by activating alarms throughout the facility. Smoke alarms provided in the dining room on the 5517 side, office on the 5517 side, dining room on the 5515 side, laundry room, bedroom hallway on the 5515 side, and basement hallway did not sound upon the testing of other smoke alarms. LALD-D called clinical nurse supervisor (CNS)-C who explained that there were two separate systems of smoke alarms present in the facility. The supplied alarms that were hardwired did not interconnect with the other system of smoke alarms that was battery operated. All smoke alarms in the facility must be interconnected together such that the activation of any alarm causes all other alarms to sound. The hard-wired power supply of smoke alarms must be maintained, and those alarms must interconnect with all supplied alarms. During the facility tour and interview on August 6, 2025, LALD-D verified the above listed fire protection and physical environment observations while accompanying on the tour and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 12 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2025, from approximately 10:25 a.m. to 12:40 p.m., the surveyor toured the facility with unlicensed person (ULP)-A, licensed assisted living director (LALD)-D and maintenance (M)-G. During the tour the surveyor observed the following: One window in resident room 3 did not open when attempted. M-G was unable to open the window when attempted and indicated it was stuck. Another window in resident room 3 did not stay open and would slam shut if not help up.	0 800		

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0 800	Continued From page 13 Window assemblies should be maintained in proper and functional working order. The crank had broken off of the bathroom window on the upper-level bathroom on the 5517 side of the facility. The window was not openable without the missing crank and there was no other means of ventilation in this bathroom. The window, assembly and opening equipment should be maintained in functional condition and the window should be openable to allow ventilation to prevent moisture buildup. The tile flooring of the basement bathroom was not watertight around the toilet, Bathroom flooring should be maintained in proper and watertight condition. The opening latch of the egress window in resident room 5 had completely become disconnected from window frame assembly. The window assembly was further damaged to prevent the window from being able to close fully and securely. The window assembly should be maintained in functional condition. An outlet cover was missing from an electrical outlet in resident room 8. Outlets should be supplied with proper electrical covers to prevent injury. The ground fault circuit indicator outlet in the lower-level bathroom was not functional and would not reset when tripped. M-G and LALD-D acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies.	0 800		

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0 800	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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 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.	0 810		

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2025, at approximately 12:10 p.m.., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. LALD-D expressed that training is done verbally with residents, but there is no recorded plan or procedures.	0 810		

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0 810	Continued From page 16 The FSEP failed to identify appropriate fire protection actions for staff. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The provided document labelled 9.06 Fire Policy included references to sprinklers and smoke compartments, which LALD-D and CNS-C acknowledged were not components of the evacuation plan for this facility. The employee actions provided in the FSEP were not site specific or accurate. During an interview on August 6, 2025, the surveyor explained the requirements for employee procedures, and FSEP documentation. LALD-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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0 910	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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: On August 5, 2025, at 11:55 a.m., via email correspondence the licensee provided the surveyor with the licensee's blank assisted living contract. The contract lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the licensee. R1 R1 was admitted to the licensee on September 29, 2018, and received assisted living services. R1's Assisted Living Contract signed on August 1, 2021, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. R2 R2 was admitted to the licensee on August 6, 2007, and received assisted living services.	0 910		

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0 910	Continued From page 18 R2's Assisted Living Contract signed on August 1, 2021, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. R3 R3 was admitted to the licensee on February 29, 2024, and received assisted living services. R3's Assisted Living Contract signed on February 29, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. On August 5, 2025, at 12:47 p.m., licensed assisted living director (LALD)-D stated the HFID number was not listed on the contract, and the would add it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 19 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) for one of one resident (R1) who was relocated and had not returned to the facility within four days.	01060		

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01060	Continued From page 20 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: On August 4, 2025, at approximately 10:45 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the provider was familiar with the current minimum assisted living requirements. R1 was admitted to the licensee on August 29, 2018, and received assisted living services. R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, grooming, bathing, medication assist, clothing assist, catheter care, and behavior management. R1's primary care provider Admit/Discharge Event Notification note dated July 23, 2025, indicated R1 was admitted to the hospital on July 17, 2025, for abdominal pain, and discharged on July 23, 2025. R1's record lacked evidence a written notice with the following required content was provided to the resident, legal representative, and designated representative: (1) the reason for the relocation; (2) the name and contact information for the	01060		

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01060	Continued From page 21 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked evidence the emergency relocation notice was delivered to the Office of Ombudsman for Long-Term Care when had not returned to the facility within four days. On August 5, 2025, at 10:19 a.m., via telephone, when asked about an emergency relocation notice, clinical nurse supervisor (CNS)-C asked the surveyor if the emergency relocation notice requirement was a new statute requirement. CNS-C asked if they must provide an emergency relocation notice when resident's go to the hospital. CNS-C stated they typically had called 911 and sent residents to the hospital. CNS-C further stated, "What statute number is this? This is new to me, I notified the case manager and contacted the hospital staff when he [referring to R1] got back". The licensee's 1.23 Emergency Relocation policy dated January 31, 2023, indicated, 1. In the event of an emergency relocation, the Assisted	01060		

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01060	Continued From page 22 Living Facility will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 2. The facility will provide contact information for the agency to which the resident may submit an appeal. 3. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. 4. Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the contract termination process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01290 SS=G	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 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 ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for one of 29 employees (unlicensed personnel (ULP)-A). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01290		

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01290	Continued From page 24 ULP-A was hired on December 28, 2020, to provide direct cares and services to residents. The licensee's staffing schedule for July 27, 2025, through September 6, 2025, indicated ULP-A was scheduled to work the day shifts (6:00 a.m. to 3:30 p.m.,) for the following dates: July 29, 30, 31, August 2, 5, 6, 7, 8, 11, 12, 13, 14, 17, 19, 20, 21, 23, 25, 26, 27, 28, 29, 31, September 1, and 2. The licensee's NETstudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) printed on August 4, 2025, indicated the "Eligible COVID-19 Study" status for ULP-A's BGS was expired on December 31, 2022. The NETStudy roster also indicated ULP-A had been disqualified and the disqualification was set aside. The licensee lacked evidence the licensee submitted a new BGS for ULP-A after the COVID-19 eligible status had expired. On August 4, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated ULP-A provided cares to residents and ULP-A worked with residents without supervision. On August 4, 2025, at 1:52 p.m., CNS-C stated they did not know the eligible COVID-19 study status was expired and they did not know they had to resubmit a BGS. On August 4, 2025, at 1:58 p.m., via email, CNS-C provided the surveyor with a letter from Minnesota Department of Health dated November 20, 2021. The letter indicated the department had set aside ULP-A's	01290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 25 disqualification (allowing ULP-A to continue working for the licensee despite the disqualification). On August 4, 2025, at 3:06 p.m., office administrator (OA)-E stated they were aware the COVID eligibility was expired, but they were not aware the needed to run a new BGS for ULP-A since their disqualification was set aside. OA-E stated they did not get any letter from the department of health to notify them ULP-A needed a new BGS done. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated BGS study will be completed on all employees and employees may not work with residents until background study has been received. The DHS website for Transition to full compliance/Minnesota Department of Human Services dated as last updated July 20, 2023, indicated, "Emergency background studies are no longer valid. If an individual who is still affiliated has not had a new fingerprint-based background study submitted since their emergency study expired, then your entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one." The DHS website for Emergency Background Studies End dated as updated July 31, 2024, indicated, "Emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant, fingerprint-based background study." It also	01290		

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01290	Continued From page 26 indicated, "Expiration dates for emergency studies are displayed as 12/31/2022 in NETStudy 2.0" and "The Background Studies Division no longer reviews new records or information for an individual who only has an emergency study in NETStudy 2.0." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620		

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01620	Continued From page 27 (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the date of the last assessment for two of two residents (R1, R2). 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	01620		

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01620	Continued From page 28 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: On August 4, 2025, at approximately 10:45 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the provider was familiar with the current minimum assisted living requirements. CNS-C stated all assessments were completed by the registered nurses (RN). CNS-C stated RNs would come into the facility and conduct assessments for a resident who was returning from the hospital including for residents returning from the hospital on weekends or a holiday. R1 was admitted to the licensee on August 29, 2018, and received assisted living services. R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, grooming, bathing, medication assist, clothing assist, catheter care, and behavior management. R1's primary care provider Admit/Discharge Event Notification note dated July 23, 2025, indicated R1 was admitted to the hospital on July 17, 2025, for abdominal pain, and discharged on July 23, 2025. R1's record included 90-day nursing assessments dated December 10, 2024, March 16, 2025, and June 27, 2025. The assessment completed on March 16, 2025, was completed six days past the 90 calendar day requirement. The assessment completed on June 27, 2025,	01620		

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01620	Continued From page 29 was completed 11 days past the 90 calendar day requirement. R1's record also included Clinical Update Review assessment completed on July 30, 2025, seven days after R1 returned to the facility following six days of hospital admission. R2 R2 was admitted to the licensee on August 6, 2007, and received assisted living services. R2's signed service plan dated January 29, 2022, indicated R2 received assistance with behavior management, diet, grooming, meal assistance, medication assistance, record vital signs, safety checks, and shopping assistance. R2's record included 90-day nursing assessments dated December 17, 2024, February 15, 2025, and May 20, 2025. The assessment completed on May 20, 2025, was completed 4 days past the 90 calendar day requirement. On August 4, 2025, at approximately 2:40 p.m., CNS-C stated the assessments were late because they did not set up Rtask (electronic medical record software) to alert the nurses to complete the 90-day assessments. The licensee's 6.01 Assessment Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 30 from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	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 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 the current service plan included all services to be provided	01640		

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01640	Continued From page 31 for one of three residents (R1). 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 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 August 4, 2025, at approximately 10:45 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the provider was familiar with the current minimum assisted living requirements. R1 was admitted to the licensee on August 29, 2018, and received assisted living services. R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, clothing, grooming, bathing, medications, catheter care, fall precaution, meals, safety checks, report pain, skin care, record vitals, record fluid intake, record output, care of personal possessions, socialization, and behavior management. The service plan did not indicate transfer and incontinence care assistance was required for R1. On August 5, 2025, at 9:53 a.m., the surveyor observed unlicensed personnel ULP-A and ULP-B assist R1 with changing their incontinence brief.	01640		

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01640	Continued From page 32 On August 5, 2025, at 10:00 a.m., ULP-A stated R1 required a two persons assist for transfers with a stand and pivot transfer technique. R1's Service Recap Summary for the month of July 2025, included to record bowel movement and position/ re-position R1; the Service Recap Summary did not include continence care/toileting assistance or transfer assistance for R1. On August 7, 2025, at 1:06 p.m., CNS-C stated R1 required assistance with dressing, bathing, clothing assist, and activity of daily living, positioning, grooming and medication assistance. On August 7, 2025, at 1:11p.m., CNS-C stated the service plan did not include positioning/transfer or toileting and stated it was an oversight. On August 7, 2025, at 1:11p.m., CNS-C stated toileting was not included on the service order to direct the ULPs to provide toileting assistance to R1. CNS-C stated it was an oversight. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan will include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 33 (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 34 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for three of three residents (R1, 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, 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: R1 R1 was admitted to the licensee on August 29, 2018, and received assisted living services. R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, grooming, bathing, medication assist, clothing assist, catheter care, and behavior management. R2 R2 was admitted to the licensee on August 6, 2007, and received assisted living services.	01730		

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01730	Continued From page 35 R2's signed service plan dated January 29, 2022, indicated R2 received assistance with behavior management, diet, grooming, meal assistance, medication assistance, record vital signs, safety checks, and shopping assistance. R3 R3 was admitted to the licensee on February 29, 2024, and received assisted living services. R3's signed service plan dated February 29, 2024, indicated R3 received assistance with behavior management, diabetes monitor, grooming, meal assistance, medication assistance, record vital signs, safety checks, and shopping assistance. R1, R2, and R3's Individualized Medication Management Plans (IMMP) lacked the following: - procedures for staff to notify an RN when problems arose. On August 6, 2025, at 4:45 p.m., via email correspondence, clinical nurse supervisor (CNS)-C stated, "Although procedures were not explicitly written in the IMMP, staff follow protocol as trained: . Prior to each medication pass, staff verify the medication using the five rights of medication administration. . If an issue arises (e.g., a discrepancy, missed dose, or side effect), staff notify the registered nurse promptly via phone or the Rtask [electronic medical record software] messaging system. We will revise the IMMP documents to reflect these practices more explicitly in accordance with Minn. Stat. § 144G.71, Subd. 5.	01730		

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01730	Continued From page 36 . We also contacted Rtask for IT Support, please see attachment titled "Email from Rtask about IMMP Update"" The licensee's 7.03 medication management Individualized Plan policy dated September 1, 2023, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record for one of one resident (R1). This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 29, 2018, and received assisted living services.	01760		

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01760	Continued From page 38 R1's signed service plan form, dated January 1, 2022, indicated R1 received assistance with, grooming, bathing, medication assistance, clothing assistance, catheter care, and behavior management. R1's record included a signed physician order entitled [hospital name] Geriatric Services Discharge Summary dated August 19, 2024, which indicated Eliquis 2.5 milligram (mg) tablet take 1 tablet 2.5 mg by mouth two times daily for atrial fibrillation. R1's record included a signed physician order dated September 23, 2024. The order indicated R1 was taking the following medications: - albuterol sulfate 90 micrograms (mcg) HFA Inhaler, inhale 1 puffs every four hours daily as needed (PRN); - allopurinol 100mg take 1/2 tablet (tab) every other day; - atorvastatin calcium 80mg 1 tab once daily; - amlodipine 10mg take 1 tab; - ferrous gluconate 324mg tab; - refresh p.m. ophthalmic ointment apply small amount in both eyes at bedtime. - sodium bicatbonet 650mg, take one tablet by mouth daily; - refresh plus 0.5% Pf Ophthalmic drop instill one drop in both eyes six times daily; and - levothyroxine 75mcg take one tablet by mouth once daily (handwritten). The physician order indicated the following medications for R1 were discontinued (medications were crossed off with a handwritten "D/C"): - acetaminophen 500mg take 1 tablet by mouth every six hours PRN;	01760		

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01760	Continued From page 39 - Ketoconazole CRE 2% apply a thin layer to affected areas once daily as needed for 30 days; and - levothyroxine 88 mcg take one tablet by mouth once daily. The physician order did not include the Eliquis order written on August 19, 2024. R1's signed physician order entitled Inter Agency Transfer form dated July 23, 2025, indicated an order to stop Eliquis. A note from the hospitalist on page 3 of the 42-page long document read, "# Intraparenchymal Hemorrhage # AMS Patient was noted to be altered on second day of hospitalization. His altered state was worse than what his baseline was based on providers that had taken care of him prior. A stat CT head was obtained which did show concerns for an intraparenchymal hemorrhage. Neurosurgery was consulted. No acute intervention was done. Repeat head CT was obtained which showed a stable hemorrhage. Likely think hemorrhage was due to chronic apixaban use. - Will stop apixaban". The document also indicated, "# Atrial Fibrillation Patient has a history of atrial fibrillation and was on chronic apixaban. This is likely thought to be the cause of his head bleed. - Recommend stopping apixaban - Recommend following up with cardiology". Page 39 of the above-mentioned form under Assessment/Plan from the neurosurgery physician written on July 19, 2025, indicated to hold all anticoagulation/antiplatelets. (Eliquis (apixaban) is an anticoagulant medication).	01760		

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01760	Continued From page 40 R1's medication administration record (MAR) for the month of July and August 2025, indicated the licensee continued to administer Eliquis 2.5 mg to R1 twice a day from July 23, 2024, through August 7, 2025. On July 6, 2025, at 9:32 a.m., via email correspondence, clinical nurse supervisor (CNS)-C indicated, "Attached are my personal notes about him, I write down my questions or comments so I don't forget when I speak with providers. The hospitalist did not send signed discontinuation orders for the eliquis -- he mentions it in the discharge orders. I was concerned why it was discontinued and wanted to get clarity from the hospitalist and/or his PCP [primary care provider], which is mentioned in my notes where I contact the providers." CNS-C's personal note entitled, RN round Review & Provider Round Notes was not signed by CNS-C nor time stamped. The note read: "RN REVIEW 7/23/25 - Received report from ortho med surge RN, [R1] to return to facility today. Reviewed medications, eliquis discontinued by hospitalist. No other new medication orders. HCMC RN unable to provide explanation why. Will contact provider. Concerned for discontinuation without cause, as hx of stroke and afib. - Contacted HCMC hospitalist and PCP about eliquis, awaiting return call." On August 7, 2025, at 11:54 a.m., the surveyor inquired if CNS-C had reviewed R1's discharge order to see why the Eliquis was stopped and referred CNS to page three of the discharge order mentioned above. CNS-C stated they looked through the document, but they might	01760		

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01760	Continued From page 41 have missed it. CNS-C further stated, "we have a hospitalist who saw [R1] for short period of time and a PCP who knows [R1] for long time" and questioned which order weighed more. The surveyor inquired if they had received an order to continue the Eliquis from the PCP. CNS-C stated they did not have an order to stop Eliquis from the PCP. On August 7, 2025, at 12:07 p.m., via telephone PCP-P stated they were contacted about Eliquis earlier this week (during the survey) on August 5, 2025. PCP-P stated they did not write an order to continue or discontinue the Eliquis for R1. PCP-P stated their expectation was that the nurse follows the discharge order to discontinue the Eliquis. PCP-P further explained if R1 was hemorrhaging like the physician note indicated, taking Eliquis would exacerbate the hemorrhaging. On August 7, 2025, at 2:42 p.m., CNS-C stated they did not place a follow up call to the hospitalist after July 23, 2025. On August 7, 2025, at 2:44 p.m., CNS-C stated they contacted the PCP office on July 23, 2025, via telephone. CNS-C stated they did not follow up with the PCP until August 5, 2025. A printout of the message CNS-C wrote to R1's PCP on August 5, 2025, at 6:53 p.m., indicated CNS-C contacted the PCP about R1's Eliquis. The message read, "I'm reviewing [R1's] discharge paperwork from HCMC. The hospitalist discontinued the Eliquis, but does not state a reasoning to why on the discharge paperwork. Did we want to continue the ELIQUIS 1 tablet (2.5 mg) by mouth two times daily? If so, please	01760		

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01760	Continued From page 42 provide written order. Thanks!" On August 7, 2025, at 2:55 p.m., CNS-C stated the reason why the Eliquis was not included on the September 23, 2024, record was because the physician order was not communicated to the pharmacy to by the transitional care unit (TCU) where R1 went after hospital discharge. The nursing team was supposed to follow-up with the pharmacy and maybe it was an oversite. The licensee's Medication and treatment Orders policy dated September 1, 2023, read, " POLICY: To ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. Procedures The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. An order for medication or treatment must be dated, signed by the prescriber and must be	01760		

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01760	Continued From page 43 current and consistent with the resident's nursing assessment. Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate In addition, based on observation, interview, and record review, the licensee failed to ensure the medication orders were accurately transcribed to the medication administration record for R1: Tylenol (acetaminophen) R1's signed physician order entitled Inter Agency Transfer form dated July 23, 2025, on page 11 of the 42-page long document, indicated an order to stop Tylenol.	01760		

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01760	Continued From page 44 R1's MAR for the month of July and August 2025, indicated a continued order for acetaminophen 500mg tablet (tab) to give1 tab by mouth every four hours as needed for pain (PRN), after the discontinuation order for acetaminophen was received on July 23, 2025. R1's MAR included documentation R1 received acetaminophen 500mg tablet, on July 27, 2025, at 10:13 p.m., for back pain. On August 5, 2025, at 1:10 p.m., the surveyor observed R1's medication supply of acetaminophen, stored in a small zip lock plastic bag. The plastic bag had the following handwritten instruction/label read; - "[R1] PRN acetaminophen 3x Daily 2 tabs By mouth" (did not mention dosage). On August 5, 2025, at 12:41 p.m., via email correspondence, the surveyor requested a prescriber order for R1's acetaminophen. On August 5, 2025, at 6:55 p.m., via email correspondence, CNS-C sent R1's signed Adult Standing Medication and Program Orders dated March 20, 2025, with the following highlighted order: - Acetaminophen/ Tylenol 500mg- 2 tab or cap (capsules) by mouth every 6 hours as needed. Do not take more than 6 tabs or caps in a 24-hour period. The Adult Standing Medication and Program Orders indicated any order written by the licensed prescriber will supersede the standing orders. On August 6, 2025, at 4:45 p.m., via email correspondence, CNS-C indicated, "We	01760		

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01760	Continued From page 45 acknowledge the discontinuation of Tylenol per the signed interagency transfer form dated July 23, 2025. The continued administration was an oversight, and we are reviewing this with our nursing and administrative team. A review of our medication reconciliation protocol is underway to prevent recurrence." Eye Drops/Eye Ointment R1's signed Physician Orders dated September 23, 2024, indicated an order for the following: - Refresh P.M. ophthalmic ointment, apply a small amount in both eyes at bedtime; and - Refresh Plus 0.5% PF ophthalmic drop, instill one drop in both eyes six times daily. R1's MAR for the month of May 2025, indicated Refresh P.M. and Refresh Plus were put on hold on May 22, 2025, at 10:49 p.m. R1's signed physician order entitled Inter Agency Transfer form dated July 23, 2025, on page 11 of the 42-page long document, indicated the following orders: - Refresh P.M. (artificial tears ointment) ophthalmic ointment, apply a small amount in both eyes at bedtime; and - Refresh Plus (carboxymethylcellulose sod) 0.5% PF ophthalmic drop, instill one drop in both eyes three times daily. R1's MAR for the month of June and July 2025, did not include the above listed eyedrops and eye ointment. R1's MAR for the month of August 2025, indicated Refresh Plus 0.5% PF ophthalmic drop, place one drop in each eye 3 times a day for dry eyes was added to the MAR on August 7, 2025,	01760		

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01760	Continued From page 46 during the survey, and was put on hold the same day. On August 6, 2025, at 4:45 p.m., via email correspondence, CNS-C indicated, "[R1] frequently refuses the use of artificial tears and Carboxymethylcellulose. These medications were temporarily placed on hold pending clarification from his provider. We have requested updated orders and will document any changes upon receipt." On August 7, 2025, at 11:16 a.m., CNS-C stated the eye drop and the eye ointment were placed on hold by the nurse in May 2025, due to R1's refusal of taking the medication. On August 7, 2025, at 11:22 a.m., via email correspondence, CNS-C provided the surveyor with the following signed orders from R1's primary care provider, dated May 15, 2025: - CHANGE: Refresh plus eyedrops; instill 1 drop in both eyes 3 times daily as needed for dry eye; and - CHANGE: Refresh Lacri-Lube ointment; apply small amount to both eyes at bedtime as needed. On August 7, 2025, at 11:22 a.m., surveyor inquired to CNS-C why the changes mentioned above were not transcribed to R1's MAR to reflect the PRN orders. CNS-C stated, "I have no answer for why it was not changed to PRN." Amlodipine R1's signed Physician Orders dated September 23, 2024, indicated the following order: - amlodipine Besylate 10mg tabs, take 1 tablet per feeding tube once daily.	01760		

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01760	Continued From page 47 R1's signed physician order entitled Inter Agency Transfer form dated July 23, 2025, on page 11 of the 42-page long document, indicated: - amlodipine Besylate 10mg tabs, take 1 tablet per feeding tube once daily. R1's MAR for month of July and August 2025, indicated R1 received amlodipine Besylate 10mg tabs, daily until August 4, 2025. The MAR indicated amlodipine was discontinued on August 4, 2025, at 5:45 p.m. On August 5, 2025, at 1:10 p.m., the surveyor observed R1's plastic medication storage bin and noted amlodipine was not included in R1's pharmacy prepacked medication supply. On August 7, 2025, at approximately 1:00 p.m., the surveyor inquired to CNS-C about R1's amlodipine discontinuation and asked the CNS to provide a signed order to discontinue the amlodipine. On August 7, 2025, at 2:30 p.m., via email correspondence, CNS-C provided the surveyor with the following Cancel RX (prescription) written on August 26, 2024, for amlodipine 10mg oral tablet. On August 8, 2025, at 8:42 a.m., via telephone Pharmacist (P-H) from the licensee's preferred pharmacy stated Amlodipine 10mg was discontinued on August 25, 2024, by R1's nephrologist, restarted on August 26, 2024, and was discontinued again by the same nephrologist on July 23, 2025. P-H stated R1's 31-day supply of amlodipine was dispensed for the last time on June 26, 2025.	01760		

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01760	Continued From page 48 On August 8, 2025, at 9:07 a.m., via email correspondence, the surveyor inquired to CNS-C why R1 was taking amlodipine until August 5, 2025 (during the survey), when the above cancel RX indicated discontinuation of amlodipine on August 26, 2024. On August 8, 2025, at 10:12 a.m., via telephone, R1's primary care provider (PCP)-F stated R1's amlodipine was managed by R1's nephrologist. PCP-F stated R1 was supposed to be on amlodipine 10mg per their record. On August 8, 2025, at 11:11 a.m., via email correspondence, CNS-C indicated, "The Amlodipine 10mg was continued by his PCP [primary care provider] [the provider's name] based on the physician orders in September 2024. He saw his Nephrologist [the nephrologist's name] in April 2025, where the amlodipine was mentioned on his after-visit summary (AVS), see attached. Please also see response from [the primary provider's name] about the amlodipine." The unsigned AVS from the nephrologist mentioned above dated April 14, 2025, indicated the following order: - amlodipine Besylate take 1 tablet (10mg) per feeding tube once daily. The primary care provider message dated August 8, 2025, at 10:47 a.m., mentioned above by CNS-C, read, "It sure sounds like there has been a lot of confusion about [R1's] medications. Please continue to hold his amlodipine until he can follow up with Nephrology. As far as our records show, he was still on amlodipine PO [by	01760		

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01760	Continued From page 49 mouth], but it looks like they D/C'd [discontinued] oral amlodipine and discharged him on "via feeding tube" which is incorrect because he does not have one. I reviewed his BP [blood pressure] log and things are looking stable. Please reach out via bridge if his systolic BP is above 150 and/or diastolic above 100." On August 11, 2025, at 8:59 a.m., via email correspondence CNS-C indicated, "Clarification Regarding Amlodipine Discontinuation - August 5, 2025 On August 5, 2025, I discontinued Amlodipine 10 mg from the resident's MAR following a medication review with Geritom Pharmacy on the evening of August 4, 2025. During this review, the pharmacist informed me that the medication had been discontinued by the resident's nephrologist, [the nephrologist's name], and provided a fax reflecting this discontinuation. At that time, I acted in accordance with standard nursing practice by: " Updating the MAR to reflect the reported discontinuation. " Submitting and receiving a discontinuation order from the pharmacy that same evening. Upon reviewing the documentation, I noted that the discontinuation order was dated August 26, 2024, and that there was a subsequent order dated September 23, 2024, signed by the primary physician. I attempted to clarify this discrepancy by contacting nephrology and left three voicemail messages regarding the matter. Due to delays in receiving a response from nephrology, I contacted the primary physician, [the provider's name] and received written orders to continue holding Amlodipine until further direction was obtained from nephrology. In that same communication, the primary physician also	01760		

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01760	Continued From page 50 provided updated blood pressure monitoring parameters. I continue to make efforts to contact nephrology to obtain final clarification regarding the Amlodipine orders. Please note: There is no new signed MD order dated August 5, 2025, in the record. I took the discontinuation action based on the pharmacist's verbal report and faxed documentation, with the intent to secure written provider confirmation thereafter." On August 11, 2025, at 10:38 a.m., via email correspondence, CNS-C indicated, " I've received a response from his nephrology team regarding the Amlodipine. The new order has been clarified and his MAR will be updated to reflect the change. Please see order attached." The following signed order for R1 entitled New Prescription Summary dated August 11, 2025, was attached to CNS-C's email: - Amlodipine Besylate 10mg oral tablet, take one tablet 10mg by mouth daily. It is ok to crush if needed. The surveyor could not discern when the amlodipine was discontinued by the provider, and why the medication orders were not clarified until the night of August 4, 2025, (the day the survey was initiated). Although requested, CNS-C did not provide an answer as to why they did not address the above-mentioned discrepancies in a timely manner. The licensee's Medication and treatment Orders policy dated September 1, 2023, read, " POLICY: To ensure a current, written prescriber's order must be obtained for any treatment or medication	01760		

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01760	Continued From page 51 administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. Procedures The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. The licensed nurse will review all medication and treatment orders for progress, effectiveness and	01760		

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01760	Continued From page 52 necessity on a regular basis and with resident change of condition. The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication was labeled with the resident's name for one of one resident (R3) who utilized insulin. 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 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21508	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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
01890	Continued From page 53 situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on February 29, 2024, and received assisted living services. R3's signed service plan dated February 29, 2024, indicated R3 received assistance with behavior management, diabetes monitor, grooming, meal assistance, medication assistance, record vital signs, safety checks, and shopping assistance. On August 5, 2025, at 9:02 a.m., the surveyor observed the medication cabinet and observed R3's Lantus insulin pen without an identifying name label and no opened-on date. The surveyor observed unlicensed personnel (ULP)-B hand the Lantus insulin pen to R3 and R3 self-administered the insulin. On August 5, 2025, at 9:11 a.m., ULP-B confirmed R3's Lantus insulin pen did not have identifying name label and contained no opened-on date. ULP-B stated they thought insulin pen was opened about three weeks ago. On August 6, 2025, at 4:45 p.m., via email correspondence, clinical nurse supervisor (CNS)-C stated, "[R3] is the only resident prescribed Lantus, and the date is typically written on the external box rather than the pen itself. We acknowledge this practice does not meet labeling standards and will revise our medication labeling procedures to ensure each insulin pen is labeled with both the resident's name and the "opened on" date to be in compliance with MN statues."	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21508	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

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01890	Continued From page 54 A Sanofi-aventis U.S LLC Pdf document last revised August 2022, entitled How to Use Your Lantus Solostar Pen read, "HOW TO STORE YOUR OPENED LANTUS SOLOSTAR PEN After its first use, don't refrigerate the Lantus SoloStar pen. Keep it at room temperature only (below 86°F). After 28 days, throw your opened Lantus pen away-even if it still has insulin in it." The licensee's undated 7.36 Insulin policy read, "1. Medications always need to be administered according to the "6 Rights" . Right person . Right medication . Right time . Right route (i.e., by mouth, eye drop, to the skin) . Right dose (i.e., how many milligrams, drops) . Right chart/record to document that the medication was taken 2. Some important tips to remember when assisting residents with self-administered insulin medications are: A. Always know what medications you are giving, what effect they have, and what their side effects are. If you are not sure about any medications, check your medication reference manual and/or call the nurse. B. Medications should be set up, given to the individual, and documented by the same staff member. Do not give out medications that another person has set up. C. To avoid confusion, it is best to give the medications as quickly as possible after they are set up. Set up the medications for one person, give them to the person, and document that they	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21508	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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
01890	Continued From page 55 were given before you set up the medications for the next person. D. Always wash your hands before setting up medications and at any time during the process if your hands have been contaminated. (See hand washing procedure) E. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: . Resident name . Name of the medication . The strength and dosage of the medication . The route . The time that the medication is to be given . Any special instructions F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. 3. Read the label and compare it with the information on the MAR three (3) times to make sure that you haven't made a mistake." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.	02410		

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DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

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02410	Continued From page 56 (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for two of two residents (R1, R4), for whom the licensee stored incontinence products. 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: On August 4, 2025, at approximately 10:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated the provider was	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21508	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

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02410	Continued From page 57 familiar with the current minimum assisted living requirements. On August 4, 2025, at approximately 11:15 a.m., during the facility tour, the surveyor observed a small closet in the hallway leading to the common bathroom on the main level across from R1's room. The closet was open with no doors and contained incontinent products for R1 and R4. The surveyor observed a posting on the closet read, "[R1's] brief" and "[R4's] brief" with arrows pointing to respective resident's rack. On August 4, 2025, at 11:50 a.m., CNS-C stated they were trying to keep the closet organized that is why the resident's names were posted, and CNS-C stated they did not see it as a privacy issue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02410		

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

Establishment Info

DR THOMAS H JOHNSON HWS
5515 PENN AVENUE SOUTH
Minneapolis, MN 55419
Parcel:

Phone:

License Info

License: HFID 21508

Risk:
License:
Expires on:
CFPM: DESIREE LORETTA PRICE
CFPM #: FM112694; Exp: 08/26/2025

Inspection Info

Report Number: F1005251076
Inspection Type: Full - Single
Date: 8/5/2025 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR DEE MOSISSA.

STAFF RAN A THERMOLABEL THROUGH THE DISHWASHER AND LATER SENT INSPECTOR A PICTURE, SHOWING THE DISHWASHER PROVIDED A TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005251076 from 8/5/2025

DESIREE PRICE

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

DR THOMAS H JOHNSON HWS
Minneapolis
County/Group:

Inspection Info

Report Number: F1005251076
Inspection Type: Full
Date: 8/5/2025
Time: 11:00 AM

Food Temperature: Product/Item/Unit: LETTUCE**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 39 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

Establishment Info

DR THOMAS H JOHNSON HWS
Minneapolis
County/Group:

Inspection Info

Report Number: F1005251076
Inspection Type: Full
Date: 8/5/2025
Time: 11:00 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Equal To 160 Degrees F.
Comment: AT LEAST 160 DEGREES F PER THERMOLABEL
Violation Issued?: No