Electronically Delivered

March 7, 2024

Licensee
Dr Thomas H Johnson HWS
2221 West 55th Street
Minneapolis, MN 55419

RE: Project Number(s) SL23749015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 23, 2024, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23749	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET 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: SL23749015 On Febuary 20, 2024, through Febuary 22, 2024, 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 six (6) residents receiving services under the Assisted Living license.	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all six (6) current residents of the facility. 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated Febuary 21, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 550		

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0 550	Continued From page 2 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. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 21, 2024, at 9:55 a.m., surveyor observed the common areas of the facility and noted the licensee lacked a posting of the grievance procedure. On February 21, 2024, at 9:57 a.m., licensed assisted living director (LALD)-C stated all the	0 550		

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0 550	Continued From page 3 required information was listed on their posting. LALD-C also stated the grievance procedure was provided in resident documents received, but LALD-C said they would update the posting to include the missing information. The licensee's 2.10 Complaint/Grievance Posting policy effective August 1, 2021, indicated licensee would post, in a conspicuous place, information about their complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 4 Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety 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). Findings include: On February 20, 2024, at 11:30 a.m., survey staff toured the facility with administrator (A)-E. It was observed that the portable fire extinguishers were tagged showing the required annual service date but lacked the records to show the required monthly visual inspections to date. During interview on February 20, 2024 at 12:00 p.m., survey staff explained to A-E that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by a staff member to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. A-E verified the findings and stated that they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 790		

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0 790	Continued From page 5 days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee 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) Employees 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 employees 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 6 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 February 20, 2024, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 01/31/2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide	0 810		

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0 810	Continued From page 7 complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on February 20, 2024, at 1:00 p.m., LALD-C stated they were currently working on developing the policy to be site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-C was unable to provide documentation showing any training offered on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by	0 810		

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0 810	Continued From page 8 third-party online software that could not be modified to include the facility-specific fire safety plans. LALD-C was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. During an interview on February 20, 2024, at 1:00 p.m., LALD-C stated she understood the requirements and would implement a training program that was compliant with statute requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that drills were completed on 1/18/24. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) 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 from the last date of the assessment. (d) 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	01620		

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01620	Continued From page 9 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. (e) 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) completed ongoing resident reassessment and monitoring that cannot exceed 90 calendar days from the last date of the 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 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: R1 R1 admitted to licensee on September 17, 2019. R1's service plan dated January 01, 2022, indicated R1 received services including	01620		

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01620	Continued From page 10 medication administration, assistance with activity daily living (ADL), behavior management, shower, and compression stocking. R1's record included Clinical Update Assessment dated October 9, 2023, and Clinical Update Assessment dated February 20, 2024, completed after survey was initiated, which exceeded 90 calendar days from the last assessment. R2 R2 admitted to the licensee on October 19, 2021. R2's service plan signed and dated January 29, 2022, indicated R5 received services including medication administration, safety checks, meal assistance, hand brace application and removal, and behavior management. R2's record included Clinical Update Assessment dated August 29, 2023, and Clinical Update Assessment dated February 20, 2024, completed after survey was initiated, which exceeded 90 calendar days from the last assessment. By email on February 22, 2024, at 11:09 a.m., clinical nurse supervisor (CNS)-A stated their electronic health record (Rtasks) automatically scheduled 90 calendar day assessments for when they needed to be completed. CNS-A stated when an unscheduled assessment was completed prior to the scheduled 90-day assessment, RTasks automatically cancels the next scheduled assessment, so the registered nurse would need to set up the next assessment date. CNS-A stated it was an oversight on their end for not selecting the "next assessment date." The licensee's 6.01 Assessments, Reviews & Monitoring policy effective August 1, 2023,	01620		

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01620	Continued From page 11 indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/21/24*
Time: 13:30:00
Report: 8041241029

Food and Beverage Establishment Inspection Report

Location:
Dr Thomas H Johnson Hws
2221 West 55th Street
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:
ID #: 0037733
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122858743
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE PLATE ON THE FRONT OF THE DISH MACHINE AND THE LID/GASKET ON THE BASEMENT CHEST FREEZER ARE DAMAGED.

Comply By: 03/21/24

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: kitchen sani bucket
Violation Issued: No

Utensil Surface Temp.: = at 164.5 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: kitchen aid cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: GE cooler: milk
Violation Issued: No

Type: Full
Date: *02/21/24*
Time: 13:30:00
Report: 8041241029
Dr Thomas H Johnson Hws

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

Inspection was completed with the Food Service Manager, Timothy Harden. Safia Hassan was the lead Health Regulation Division Nurse Evaluator. Facility had six residents on site at time of inspection. Meals are prepared on site by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood and FRP covered cabinets with a hollow base, and vinyl tile flooring. All found to be in good condition.

Establishment has a two basin sink and a separate portable handwashing sink. Discussed designating one basin of the two basin sink for handwashing. The portable hand sink is not permanently plumbed. The Beko dish machine had a utensil surface temperature of at lest 160F.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Chlorine sanitizer concentration
-Vomit clean up procedures
-Thermometer calibration
-Restrictions concerning serving a highly susceptible population

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041241029 of 02/21/24.

Certified Food Protection Manager: Timothy Harden

Certification Number: fm118903 Expires: 09/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Timothy Harden
Manager

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
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