



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 9, 2025

Licensee
DR THOMAS H JOHNSON HWS
5518 Oliver Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL26116016

Dear Licensee:

On April 3, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 9, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 19, 2025

Licensee

DR THOMAS H JOHNSON HWS

5518 Oliver Avenue South

Minneapolis, MN 55419

RE: Project Number(s) SL26116016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 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 . . ."

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,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee L. Anderson, Supervisor

State Evaluation Team

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

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 5518 OLIVER 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: SL#26116016-0 On January 7, 2025, through January 9, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 6 residents, all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 640	Continued From page 3	0 640			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors 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: During a facility tour on January 7, 2025, 11:00	0 640			

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0 640	Continued From page 4 a.m., the surveyor observed a telephone on the desk in the common room on the main level of the house. There was no 911 posting near the telephone. On January 8, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated that this phone was a facility telephone and she did not know why 911 was not posted near the telephone. The licensees 2.21 Emergency / 911 policy, dated September 21, 2023, did not indicate 911 should be posted near telephones used by residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680			

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0 680	Continued From page 5 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's undated emergency preparedness plan lacked documentation of annual review, and the following required content: -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise).	0 680			

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0 680	Continued From page 6 On January 8, 2025, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-C stated that the only documentation of EP exercises was from staff meetings where EP policies were reviewed with staff and LALD/RN-C thought that was sufficient for an exercise. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy, dated August 31, 2023, indicated the licensee would have in place, an EP program that would be in alignment with the Centers for Medicare and Medicaid Services (CMS) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780			

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0 780	Continued From page 7 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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, from approximately 10:50 a.m. to 12:35 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and maintenance contractor (MC)-B. During the tour, the surveyor asked MC-B to open the windows in the resident sleeping rooms for measurement. The noncompliant measurements were as follows:	0 780			

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0 780	Continued From page 8 OCCUPIED SLEEPING ROOMS: Resident sleeping room 1: One window measuring 39 inches clear width, 19 inches clear height, and 741 square inches total open area for each window. Resident sleeping room 2: One window measuring 41 inches clear width, 17 inches clear height, and 697 square inches total open area for each window. Resident sleeping room 3: One window measuring 23.5 inches clear width, 18.5 inches clear height, and 434.75 square inches total open area for each window. Resident sleeping room 8: One window measuring 41 inches clear width, 18 inches clear height, and 738 square inches total open area for each window. Resident sleeping room 9: One window measuring 24.5 inches clear width, 18.5 inches clear height, and 453.25 square inches total open area for each window. The windows in resident sleeping rooms 1, 2, 3, 8 and 9 did not meet the minimum requirements for opening height. The windows in bedrooms 3 and 9 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying	0 780			

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0 780	Continued From page 9 bedroom for resident occupancy. On January 7, 2025 the surveyor explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. The egress window well to unoccupied resident room 4 had a fence gate installed at the top of the well opening. The gate was tied to the post at the opening side and secured shut such that it was not be readily openable and obstructed egress from resident room 4. Several discarded cigarette butts were laying in the rear yard and in the egress well for resident room 4. Cigarette butts should be properly disposed of to mitigate risk of fire. TIME PERIOD FOR CORRECTION: Immediate	0 780			
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	0 810			

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0 810	Continued From page 10 evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the facility fire safety and evacuation plan (FSEP) with required content, to make the plan readily available, and to provide required training. 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 potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 11 The findings include: On January 7, 2025, from 10:50 a.m. to 12:35 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and maintenance contractor (MC)-B. On January 7, 2025, at 12:40 p.m., after the facility tour, the surveyor asked for facility documents showing the facility FSEP, employee and resident evacuation training, and facility evacuation drills. FIRE SAFETY AND EVACUATION PLAN: The document the LALD-A represented as including the FSEP, titled, Emergency Preparedness, dated January 31, 2023, referred to the facility's Appendix Z emergency preparedness plan procedures which included the facility will conduct, at minimum, two emergency preparedness drills every 12 months that would include fire/evacuation drills. The document did not include specific actions employees should take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. FIRE SAFETY AND EVACUATION PLAN AVAILABILITY On January 7, 2025, at 12:40 p.m., LALD-A acknowledged the FSEP documentation was not located in the facility, but on a computer at a nearby office. LOCATION AND NUMBER OF RESIDENT SLEEPING ROOMS The surveyor observed the facility floor plans with the facility divided into four different areas posted on the wall in each of the sleeping areas. The posted floor plans did not illustrate room locations within the facility, nor did the plans include room numbers for resident rooms.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 5518 OLIVER 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	
0 810	Continued From page 12 TRAINING The surveyor requested documentation verifying staff training occurred regarding the facility's FSEP staff training upon hire and at least twice a year thereafter. The surveyor was shown a variety of training documents through an online training software system, but the online documents did not show any training related to the facility's FSEP or verify current staff completed FSEP training as required. The surveyor requested documentation verifying resident training on the facility's FSEP evacuation and drill information. The facility provided the surveyor with six pages of "Resident Notes" ranging from June 2024 to January 2025 showing the facility offered fire evacuation training and drills, but the documents did not include the educational content of fire procedures for residents, resident movement, evacuation or relocation during a fire or similar emergency. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			
03090 SS=F	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 5518 OLIVER 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
03090	Continued From page 13 Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a 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 January 7, 2025, at 11:00 a.m., upon entering the facility, the surveyor observed two entrances accessible by visitors to the facility, and one lacked the required notice for electronic monitoring. On January 8, 2025, at 12:30 p.m., licensed assisted living director (LALD)-A stated she thought there had been a sign at both entrances with the required verbatim notice for electronic monitoring. The licensee's 2.15 Electronic Monitoring policy, dated January 31, 2023, indicated that signs are installed at each facility entrance accessible to visitors that read: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS		STREET ADDRESS, CITY, STATE, ZIP CODE 5518 OLIVER AVENUE SOUTH MINNEAPOLIS, MN 55419			
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03090	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 01/07/25
Time: 12:25:00
Report: 1039251006

Food and Beverage Establishment Inspection Report

Page 1

Location:

Dr Thomas H Johnson Hws
5518 Oliver Avenue South
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:

ID #: 0038435
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.

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

3-302.11A(1) ** Priority 1 **

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

SHELL EGGS STORED ABOVE DELI MEAT IN REFRIGERATOR. PERSON-IN-CHARGE WILL STORE EGGS IN LEAK-PROOF SECONDARY CONTAINER OR STORE EGGS BENEATH READY-TO-EAT FOODS.

Comply By: 01/07/25

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Utensil Surface Temp: = at >160 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: AMBIENT
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Type: Full
Date: 01/07/25
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Food and Beverage Establishment Inspection Report

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Process/Item: FROZEN

Temperature: Degrees Fahrenheit - Location: BASEMENT CHEST FREEZER

Violation Issued: No

Process/Item: AMBIENT

Temperature: 40 Degrees Fahrenheit - Location: BASMENT REFRIGERATOR

Violation Issued: No

Process/Item: FROZEN

Temperature: Degrees Fahrenheit - Location: BASEMENT FREEZER

Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Robyn Woolley.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade. There is an additional refrigerator/freezer as well as a chest freezer in the basement. There is a food dry store in the basement.

A modular handwashing sink is present and in-use for handwashing only. A kitchen sink is present.

A residential dishwashing machine is present in the kitchen. During inspection, a run of the dish machine was started with a color-change thermos test strip. Results of the run where shared by person-in-charge via email showing a rinse temperature of >160 degrees F.

A supply of single-use gloves is present in kitchen.

A thin-probe food thermometer is present in kitchen.

A irreversible waterproof thermometer is present in kitchen for use measuring dishwashing machine temperatures.

A COPY OF THE MDH EMPLOYEE ILLNESS LOG WAS LEFT WITH PERSONS-IN-CHARGE AFTER REVIEWING.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, vomit clean-up procedures, sanitizing., all orders on this report.

Type: Full
Date: 01/07/25
Time: 12:25:00
Report: 1039251006
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Food and Beverage Establishment Inspection Report

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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 1039251006 of 01/07/25.

Certified Food Protection Manager Kimberly Jones

Certification Number: FM89084 Expires: 08/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Alice Williams
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us