



STATE LICENSING COMPLIANCE REPORT

Report #: HL215087434C

Date Concluded: April 12, 2023

Name, Address, and County of Facility

Investigated:

Dr. Thomas Johnson Housing with Services
5515 Penn Avenue South
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Rhylee Gilb, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2023
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL215087434C</p> <p>On April 4, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 7 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for HL215087434C, tag identification 0990.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>		
0 990 SS=D	<p>144G.52 Subd. 2 Prerequisite to termination of a contract</p> <p>(a) Before issuing a notice of termination of an</p>	0 990			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2023
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
0 990	Continued From page 1 assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2023
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 990	<p>Continued From page 2</p> <p>telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide a written termination notice at least seven days after the pre-termination meeting was held for one of two residents (R1) reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1's medical record was reviewed. R1's service plan dated August 11, 2022, indicated R1's services included assistance with continence care, dressing/grooming, medication set-up, transfers, bathing, escorts with wheelchair and behavior management of anxiety and sleep cycle issues.</p> <p>R1's resident agreement (assisted living contract) dated August 11, 2022, indicated the facility may initiate an expedited termination if the resident engages in conduct that substantially interferes with their own health or safety.</p> <p>R1's progress notes dated November 1, 2022</p>	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/04/2023
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 990	<p>Continued From page 3</p> <p>through January 13, 2023 were reviewed. R1 had several wound care refusals for dressing changes, assessment and wound care medical appointments. R1 also had instances of smoking while in his room and use of illicit substances.</p> <p>A pre-termination meeting summary dated December 28, 2022, indicated the meeting was held on the same day at 2:00 p.m. and in attendance was registered nurse (RN)-A, R1, the ombudsman, R1's case manager and a resident supervisor for the facility. R1's behaviors that violated the assisted living agreement included using illegal substances on site and non-compliance with cares and facility policies.</p> <p>A written termination notice dated December 29, 2022, issued to R1 indicated an expeditated 15 day termination notice was provided regarding the listed behaviors in the pre-termination meeting. Expected termination date was January 13, 2023.</p> <p>The notice was provided one day following the pre-termination meeting.</p> <p>R1's progress note dated January 12, 2023, indicated R1 discharged another facility.</p> <p>During an interview on April 4, 2022, at 9:00 a.m., licensed assisted living director (LALD)-B stated regarding R1's discharge, the ombudsman alleged the termination of services was "illegal" and R1 transferred unsafely to the new facility. LALD-B stated that was untrue, there was appropriate reasons for discharge and R1 transfered safely to another licensed provider. LALD-B stated R1 later withdrew his termination appeal.</p> <p>TIME PERIOD OF CORRECTION: Seven (7)</p>	0 990			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2023
NAME OF PROVIDER OR SUPPLIER DR THOMAS H JOHNSON HWS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 990	Continued From page 4 Days	0 990			