Electronically Delivered

April 14, 2026

Licensee
DR THOMAS H JOHNSON HWS
2221 West 55th Street
Minneapolis, MN 55419

RE: Project Number(s) SL23749016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 2026, 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 . . ."

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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,

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 _____	03/26/2026

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: SL23749016-0 On March 24, 2026, through March 26, 2026, 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 (5) residents; 5 receiving services under the Assisted Living Facility 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 1 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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:	0 780		

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0 780	Continued From page 2 (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 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 780		

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0 780	Continued From page 3 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) 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 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 4 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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.	0 810		

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0 810	Continued From page 5 (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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related	0 810		

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0 810	Continued From page 6 the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500		

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01500	Continued From page 7 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each twelve (12) months of employment for one of two employees (unlicensed personnel (ULP)-C). 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	01500		

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01500	Continued From page 8 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on December 20, 2024, and began providing assisted living services. ULP-C's employee record lacked documentation of eight hours of annual training completed within a 12-month period for 2025. On March 26, 2026, at 12:17 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated annual training was assigned for all employees at the same time each year, and had not yet been assigned for 2026. LALD/CNS-A stated ULP-C had been hired after the training was assigned in 2025. The licensee's 5.06 Annual Required Staff Training policy, dated January 1, 2023, indicated all staff that perform direct care services at [licensee] must complete at least eight (8) hours of annual training for each twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=D	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	01620		

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01620	Continued From page 9 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. (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	01620		

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01620	Continued From page 10 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 a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for one of two 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: R1 was admitted to the licensee on March 7, 2024, and began receiving assisted living services. R1's Service Plan Waiver- Addendum to Contract signed December 21, 2025, indicated R1's services included assistance with grooming, medication administration, vital signs, and application of a prosthetic device. R1's record included 90-day assessments dated September 13, 2025, and December 20, 2025, indicating 99 days had passed between assessments.	01620		

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01620	Continued From page 11 On March 26, 2026, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware assessments had been late. LALD/CNS-B did not indicate why the assessment was late. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the residents and could not exceed 90 calendar days from the last date of assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	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.	01640		

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 _____	03/26/2026

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
01640	Continued From page 12 (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 interview and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative for one of two 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 7, 2024, and began receiving assisted living services. R1's Service Plan Waiver- Addendum to Contract signed December 21, 2025, indicated R1's services included blood pressure monitoring and recording daily. R1's Service Plan Waiver - Addendum to Contract, unsigned, and effective March 24, 2026, indicated R2's blood pressure was monitored and recorded two times daily.	01640		

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 _____	03/26/2026

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
01640	Continued From page 13 R1's service plan changes lacked authentication or signature from R1 or R1's representative. On March 23, 2026, at 12:19 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the blood pressure monitoring was increased at a recent doctor visit. CNS/LALD-A stated they thought they had fourteen days to have the service plan updated and authenticated. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans and any revisions would include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	01700		

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 _____	03/26/2026

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
01700	Continued From page 14 medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 a face-to-face medication management assessment to include all required content for one of two residents (R2) who received medication management services. 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: During the entrance conference on March 24, 2026, at 10:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication	01700		

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 _____	03/26/2026

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
01700	Continued From page 15 management services to all the licensee's residents. R2 was admitted to the licensee on September 30, 2025, and began receiving assisted living services. R2's record included a Service Plan (Waiver) - Addendum to Contract Agreement signed on September 30, 2025, which indicated R2's services included medication set up and medication assistance. R2's record included nursing assessments completed on August 20, 2025 (pre-admission), September 30, 2025 (admission), October 14, 2025 (14-day), December 22, 2025, and February 18, 2025. All the nursing assessments lacked the following required content: - identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues; and - identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medication and provide instruction to the resident and legal or designated representative on interventions to manage the resident's medications and prevent diversion of medications. On March 26, 2026, at 12:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware required content was missing from R2's medication assessment. The licensee's undated 7.03 Individualized	01700		

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 _____	03/26/2026

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
01700	Continued From page 16 Medication Management Plan policy dated September 1, 2023, indicated a current medication management record would be developed for each resident based on the resident's assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (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;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

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01730	Continued From page 17 (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 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 plan with the required content 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 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	01730		

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 _____	03/26/2026

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
01730	Continued From page 18 R1 was admitted to the licensee on March 7, 2024, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract signed on December 21, 2025, indicated R1's services included medication set up and assistance. R1's Individualized Medication Management Plan completed on February 19, 2026, lacked the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel. R2 R2 was admitted to the licensee on September 30, 2025, and began receiving assisted living services. R2's record included a Service Plan (Waiver) - Addendum to Contract Agreement signed on September 30, 2025, indicated R2's services included medication set up and medication assistance. R2's Individualized Medication Management Plan completed on February 18, 2026, lacked the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel (ULP).	01730		

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	23749	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

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01730	Continued From page 19 On March 24, 2026, at 11:57 a.m., the surveyor observed ULP-C assisting R1 with medication administration. On March 26, 2026, at 12:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware that required content was missing from the individualized medication management plans. The licensee's 7.03 Medication Management Individualized Plan policy dated September 1, 2023, indicated individualized medication management plans would include the following: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel (ULP). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=F	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:	01890		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

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01890	Continued From page 20 Based on observation, interview, and record review, the licensee failed to ensure medications were maintained in the original container in which they were 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 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on October 19, 2021, and began receiving assisted living services. R3's Service Plan (Waiver) - Addendum to Contract signed on December 2, 2025, indicated R3's services included medication assistance. On March 25, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R3. During medication preparation, the surveyor observed resealable plastic bags of medication in R3's medication caddy with handwritten labels identifying hydroxyzine and acetaminophen. ULP-F stated that all residents as needed (PRN) medications were repackaged and labeled by the registered nurses. ULP-F stated the original containers of medications were kept at another facility in the nurse's office and they refilled the medication	01890		

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 _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

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01890	Continued From page 21 caddies and bins twice weekly. On March 26, 2026, at 12:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware that medications need to remain in their original containers. LALD/CNS-A stated they purchased over the counter (OTC) medications in bulk and repackaged them to distribute among the residents who had the medications ordered. The licensee's 7.11 Medication Storage policy dated September 1, 2023, indicated all medications managed by [licensee] would be stored according to manufacturer's instructions. The licensee's 7.43 Medications and Treatment - Over the Counter (OTC) Medication policy dated August 1, 2001, indicated medications would remain in original labeled containers, checked for expiration, and be stored securely. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DR THOMAS H JOHNSON HWS
2221 WEST 55TH STREET
Mineapolis, MN 55419
Hennepin County
Parcel:

Phone:

License Info

License: HFID 23749

Risk:
License:
Expires on:
CFPM: Sheron R. Mack
CFPM #: 125183; Exp: 09/16/2027

Inspection Info

Report Number: F1051261070
Inspection Type: Full - Single
Date: 3/24/2026 Time: 11:00:00 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, MICHELLE WINTERS.

DISCUSSED THE FOLLOWING WITH THE FOOD SERVICE STAFF, SHERON:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS
HIGHLY SUSCEPTIBLE POPULATION

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 St Cloud District Office inspection report number F1051261070 from 3/24/2026

Sheron Mack
Food Service Staff

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

DR THOMAS H JOHNSON HWS
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1051261070
Inspection Type: Full
Date: 3/24/2026
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: DELI HAM**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Ambient Air
Location: Upright Cooler at 41 Degrees F.
Comment: KITCHEN 2
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

DR THOMAS H JOHNSON HWS
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1051261070
Inspection Type: Full
Date: 3/24/2026
Time: 11:00:00 AM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL23749016-0	**Date:** 3/24/2026
Facility Name: DR THOMAS H JOHNSON HWS	
Facility Address: 2221 W 55th St, Minneapolis, Minnesota 55419	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: The garage ceiling located below the assisted living space was observed to have a hole in the sheetrock, compromising the required occupancy separation between the garage and the resident living area above.

3. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments: A chain door guard lock was installed on a labeled emergency egress door inside resident room 4.

4. Smoking shall be prohibited where conditions are such as to make smoking a hazard, and in spaces where flammable or combustible materials are stored or handled. [Minn. Stat. 144G.45 subd. 2; MSFC 310.2]

   Comments: Evidence of smoking inside the attached garage, including cigarette butts and ash. The garage space was filled with combustible material.

5. Where smoking is permitted, suitable noncombustible ashtrays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: An approved cigarette disposal receptacle was not provided or utilized outside the office door on the lower level. A plastic flowerpot was used as an ashtray.

6. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Cigarette butts were discarded on a wooden deck and within wooden raised flower beds located at the front of the facility.

7. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments: A non-UL listed extension cord was in use inside Resident Room 6. Additionally, a power strip in the living room was observed with another power strip connected to it to supply power to additional devices.

8. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An extension cord was observed in the office being run to devices. The cord was affixed to the wall running up and around a door frame.

9. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: No smoke alarms in the facility were listed as UL 217 complaint. No documentation on the models being used specifically states that they meet the standard.

10. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

    Comments: In the basement, the electrical panel was blocked by boxes and plastic totes.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: During testing of the smoke alarms, the smoke alarm in the laundry room did not activate with the other smoke alarms within the facility.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: In the room off the kitchen, baseboard heating elements were missing the protective covers, creating a potential burn hazard. The main level bathroom exhaust fan did not work. There was water damage on the garage ceiling. The kitchen was located directly above the damaged area.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The drill documentation provided at the time of survey indicated that the licensee failed to ensure fire drills were conducted in accordance with required standards. Documentation indicated that when evacuation drills were conducted all shifts participated. Evacuation drills were not conducted on each shift under normal working conditions.