



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

June 26, 2024

Licensee  
Precious Lives Home Vadnais Heights LLC  
60 Suzanne Avenue  
Vadnais Heights, MN 55127

RE: Project Number(s) SL34177015

Dear Licensee:

On June 18, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 23, 2024, survey were corrected. 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 that reads 'Casey DeVries'.

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

AH

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 000}                                                                   | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, this correction order(s) has<br/>been issued pursuant to a survey.</p> <p>Determination of whether a violation has been<br/>corrected requires compliance with all<br/>requirements provided at the Statute number<br/>indicated below. When Minnesota Statute<br/>contains several items, failure to comply with any<br/>of the items will be considered lack of<br/>compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL34177015-1</p> <p>On June 18, 2024, the Minnesota Department of<br/>Health conducted a follow-up survey at the above<br/>provider to follow-up on orders issued pursuant to<br/>a survey completed on April 23, 2024. At the time<br/>of the survey, there were three residents: three<br/>receiving services under the Assisted Living<br/>license. As a result of the follow-up survey, the<br/>licensee is in substantial compliance.</p> | {0 000}                                                                                         |                                                                                                                          |  |                                                                    |
| {0 110}<br>SS=C                                                           | <p>144G.10 Subdivision 1a Assisted living director<br/>license required</p> <p>Each assisted living facility must employ an<br/>assisted living director licensed or permitted by<br/>the Board of Executives for Long Term Services<br/>and Supports.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 110}                                                                                         |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 110}                                                                   | Continued From page 1<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 110}                                                                   |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                                           | <b>144G.41 Subd 1 (13) (i) (B) Minimum<br/>requirements</b><br><br>(13) offer to provide or make available at least the<br>following services to residents:<br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 480}                                                                   |                                                                                                                          |  |                                                                    |
| {0 660}<br>SS=F                                                           | <b>144G.42 Subd. 9 Tuberculosis prevention and<br/>control</b><br><br>(a) The facility must establish and maintain a<br>comprehensive tuberculosis infection control<br>program according to the most current<br>tuberculosis infection control guidelines issued by<br>the United States Centers for Disease Control<br>and Prevention (CDC), Division of Tuberculosis<br>Elimination, as published in the CDC's Morbidity<br>and Mortality Weekly Report. The program must<br>include a tuberculosis infection control plan that<br>covers all paid and unpaid employees,<br>contractors, students, and regularly scheduled<br>volunteers. The commissioner shall provide<br>technical assistance regarding implementation of<br>the guidelines.<br>(b) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by: | {0 660}                                                                   |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE</b><br><b>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 660}                                                                   | Continued From page 2<br><br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {0 660}                                                                                               |                                                                                                                          |  |                                                                    |
| {0 680}<br>SS=F                                                           | <b>144G.42 Subd. 10</b> Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {0 680}                                                                                               |                                                                                                                          |  |                                                                    |
| {0 780}<br>SS=F                                                           | <b>144G.45 Subd. 2 (a) (1)</b> Fire protection and<br>physical environment<br><br>(a) Each assisted living facility must comply with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 780}                                                                                               |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 780}                                                                   | Continued From page 3<br><br>the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 780}                                                                                         |                                                                                                                          |  |                                                                    |
| {0 790}<br>SS=F                                                           | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {0 790}                                                                                         |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 790}                                                                   | Continued From page 4<br><br>located so that the travel distance to the nearest<br>fire extinguisher does not exceed 75 feet, and<br>maintained in accordance with the State Fire<br>Code; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {0 790}                                                                   |                                                                                                                          |  |                                                                    |
| {0 810}<br>SS=F                                                           | <b>144G.45 Subd. 2 (b)-(f) Fire protection and<br/>physical environment</b><br><br>(b) Each assisted living facility shall develop and<br>maintain fire safety and evacuation plans. The<br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping<br>rooms;<br>(2) employee actions to be taken in the event of<br>a fire or similar emergency;<br>(3) fire protection procedures necessary for<br>residents; and<br>(4) procedures for resident movement,<br>evacuation, or relocation during a fire or similar<br>emergency including the identification of unique<br>or unusual resident needs for movement or<br>evacuation.<br>(c) Employees of assisted living facilities shall<br>receive training on the fire safety and evacuation<br>plans upon hiring and at least twice per year<br>thereafter.<br>(d) Fire safety and evacuation plans shall be<br>readily available at all times within the facility.<br>(e) Residents who are capable of assisting in<br>their own evacuation shall be trained on the<br>proper actions to take in the event of a fire to<br>include movement, evacuation, or relocation. The<br>training shall be made available to residents at | {0 810}                                                                   |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34177 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>06/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PRECIOUSLIVESHOMEVADNAISHEIGHT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>60 SUZANNE AVENUE<br>VADNAIS HEIGHTS, MN 55127                                  |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 810}                                                            | Continued From page 5<br><br>least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                     | {0 810}                                                         |                                                                                                                          |  |                                                   |
| {0 970}<br>SS=C                                                    | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 970}                                                         |                                                                                                                          |  |                                                   |
| {01500}<br>SS=F                                                    | 144G.63 Subd. 5 Required annual training<br><br>(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:<br>(1) training on reporting of maltreatment of                                                                                                                                       | {01500}                                                         |                                                                                                                          |  |                                                   |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34177 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>06/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PRECIOUSLIVESHOMEVADNAISHEIGHT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>60 SUZANNE AVENUE<br>VADNAIS HEIGHTS, MN 55127                                  |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {01500}                                                            | Continued From page 6<br><br>vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased | {01500}                                                         |                                                                                                                          |                          |                                                   |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                                   | Continued From page 7<br><br>incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {01500}                                                                |                                                                                                                          |  |                                                                 |
| {01530}<br>SS=D                                                           | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. | {01530}                                                                |                                                                                                                          |  |                                                                 |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34177                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>06/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PRECIOUSLIVESHOMEVADNAISHEIGHT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>60 SUZANNE AVENUE<br>VADNAIS HEIGHTS, MN 55127 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {01530}                                                            | Continued From page 8<br><br>Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {01530}                                                                                 |                                                                                                                          |  |                                                   |
| {02410}<br>SS=F                                                    | 144G.91 Subd. 13 Personal and treatment privacy<br><br>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.<br>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.<br>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {02410}                                                                                 |                                                                                                                          |  |                                                   |

Minnesota Department of Health

|                                                                           |                                                                                                                              |                                                                                                       |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE</b><br><b>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
|                                                                           |                                                                                                                              |                                                                                                       |                                                                                                                          |  |                                                                    |



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

May 17, 2024

Licensee

Precious Lives Home Vadnais Heights

60 Suzanne Avenue

Vadnais Heights, MN 55127

RE: Project Number(s) SL34177015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **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 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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>**

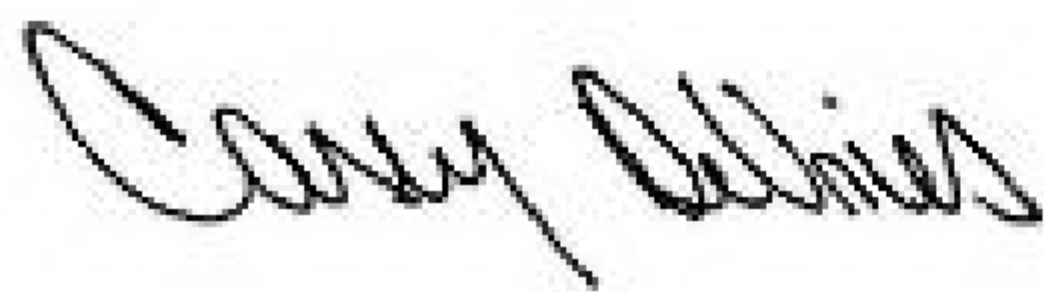
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor  
State Evaluation Team  
Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)  
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                              |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34177 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          | (X3) DATE SURVEY COMPLETED<br><br>04/23/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PRECIOUSLIVESHOMEVADNAISHEIGHT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>60 SUZANNE AVENUE<br>VADNAIS HEIGHTS, MN 55127                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 000                                                              | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When the Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL34177015-0</p> <p>On April 15, 2024, to April 23, 2024, 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 four residents, all of whom received services under the Assisted Living license.</p> <p>An immediate correction order was identified on April 15, 2024, issued for SL34177015-0, tag identification 1290.</p> <p>On April 16, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.</p> | 0 000                                                           | <p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</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> |                          |                                              |
| 0 110<br>SS=C                                                      | 144G.10 Subdivision 1a Assisted living director license required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 110                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                              |

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:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 110                                                                     | <p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record on the Board of Executives for Long-Term Services and Support (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors.</p> <p>This practice resulted in a level one violation (a violation that has no 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).</p> <p>These findings include:</p> <p>The licensee's Staff List indicated owner/LALD (O/LALD)-D was hired on July 1, 2018.</p> <p>On April 15, 2024, at 7:09 a.m., during survey preparation, the surveyor observed O/LALD-D's profile on the BELTSS website which indicate O/LALD-D was not listed as the director of record for the licensee.</p> <p>On April 15, 2024, at 9:46 a.m., during the entrance conference, owner/house manager (O/HM)-C stated O/LALD-D was one of the licensee's owners and their current LALD.</p> | 0 110                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                                     | <p>Continued From page 2</p> <p>O/HM-C stated they did not know a LALD was required to be register as the licensee's director of record on the BELTSS website and inquired how it could be done. The surveyor provided the BELTSS website information.</p> <p>On April 15, 2024, at 10:30 a.m., during the facility tour, the surveyor observed O/LALD-D's license, expiration date of October 31, 2024, posted on the wall near the nursing and unlicensed personnel (ULP) station.</p> <p>On April 16, 2024, at 8:15 a.m., O/LALD-D stated they were the LALD for the licensee.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 0 110                                                                                           |                                                                                                                          |  |                                                        |
| 0 480<br>SS=F                                                             | <p><b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b></p> <p>(13) offer to provide or make available at least the following services to residents:<br/>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</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</p>                          | 0 480                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                                     | Continued From page 3<br><br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and<br>Beverage Establishment Inspection Report<br>(FBEIR) dated April 15, 2024, for the specific<br>Minnesota Food Code violations. The Inspection<br>Report was provided to the licensee within 24<br>hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer<br>to the FBEIR for any compliance dates.                                                                                                                                                                                                                 | 0 480                                                                                           |                                                                                                                          |  |                                                        |
| 0 660<br>SS=F                                                             | 144G.42 Subd. 9 Tuberculosis prevention and<br>control<br><br>(a) The facility must establish and maintain a<br>comprehensive tuberculosis infection control<br>program according to the most current<br>tuberculosis infection control guidelines issued by<br>the United States Centers for Disease Control<br>and Prevention (CDC), Division of Tuberculosis<br>Elimination, as published in the CDC's Morbidity<br>and Mortality Weekly Report. The program must<br>include a tuberculosis infection control plan that<br>covers all paid and unpaid employees,<br>contractors, students, and regularly scheduled<br>volunteers. The commissioner shall provide<br>technical assistance regarding implementation of<br>the guidelines.<br>(b) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced | 0 660                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                                     | <p>Continued From page 4</p> <p>by:<br/>Based on observation, interview, and record review, the licensee failed to ensure annual tuberculosis (TB) training was completed for two of two employees (owner/clinical nursing supervisor (O/CNS)-A, unlicensed personnel (ULP)-B).</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) 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).</p> <p>The findings include:</p> <p>O/CNS-A<br/>O/CNS-A was hired on January 4, 2021, to provide direct supervision to ULPs, assessments and direct care services to residents.</p> <p>On April 15, 2024, the surveyor observed O/CNS-A performing their CNS duties throughout the day.</p> <p>O/CNS-A's employee record included a Precious Lives Home Orientation Checklist form which indicated O/CNS-A completed their initial TB training on January 9, 2021. O/CNS-A's employee record lacked further TB training required to be completed annually.</p> <p>ULP-B<br/>ULP-B was hired on February 9, 2023, to provide direct care services to residents.</p> <p>On April 16, 2024, at 8:32 a.m., the surveyor</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                                     | <p>Continued From page 5</p> <p>observed ULP-B administering medications for R1.</p> <p>ULP-B's employee record included a Precious Lives Home Orientation Checklist form which indicated ULP-B completed their initial TB training on February 9, 2023. ULP-B's employee record lacked further TB training required to be completed annually.</p> <p>On April 17, 2024, at 9:34 a.m., owner/house manager (O/HM)-C and O/CNS-G stated they did not realize annual TB training was not completed for O/CNS-A and ULP-B. O/HM-C and O/CNS-G stated they assign training to employees to be completed in Rtask (charting software). They stated they were aware of the annual TB training requirement but had not been assigning it to their staff.</p> <p>The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive TB education annually.</p> <p>The Minnesota Department of Health TB FAQ indicated each provider licensed by MDH is required to complete a TB risk assessment annually. Further, all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification.</p> <p>The licensee's TB risk assessment completed on January 15, 2024, indicated the licensee was at a low risk level. It further indicated, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure (both occupational and nonoccupational) risk factors, the signs and symptoms of TB disease, and TB infection control</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 660                                                                     | Continued From page 6<br><br>policies and procedures."<br><br>The licensee's Tuberculosis<br>Screening/Prevention policy dated August 1,<br>2021, indicated, "on-going education regarding<br>TB will be provided annually as part of the<br>infection control training."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 660                                                                                           |                                                                                                                          |  |                                                        |
| 0 680<br>SS=F                                                             | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site. | 0 680                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                     | <p>Continued From page 7</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors.</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 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).</p> <p>The findings include:</p> <p>On April 17, 2024, the licensee's Emergency Preparedness Plan, undated, was reviewed and lacked the following:</p> <ul style="list-style-type: none"><li>-Evidence of annual update including documentation of the date of review and any updates made to the plan based on the review;</li><li>-Documentation of the licensee's the risk assessment;</li><li>-Evidence of an all-hazards approach, including EIDs, as applicable;</li><li>-Evidence the licensee categorized the various probable risks/hazards by likelihood of occurrence;</li><li>-Evidence the licensee developed strategies for addressing facility &amp; community-based risks (i.e.: evacuation plans, staffing surges/shortages,</li></ul> | 0 680                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                     | <p>Continued From page 8</p> <p>back-up plans);</p> <p>-Evidence of quarterly update for their missing resident plan quarterly;</p> <p>-Evidence the licensee identified at risk population needs like maintaining independence, communication, transportation, supervision and medical care.</p> <p>-Evidence the licensee identified which staff would assume specific roles in another's absence through succession planning and delegation of authority.</p> <p>-Evidence a qualified person was designated, who is authorized in writing, to act in the absence of the administrator.</p> <p>-Evidence of a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response</p> <p>-Evidence the licensee developed and implemented EP policies/procedures (P/P) based on the EP, risk assessment &amp; communication plan</p> <p>-Evidence the licensee developed and implemented EP P/P to address the following whether evacuated or shelter in place for staff/residents:</p> <ul style="list-style-type: none"><li>-Food, water, medical supplies, pharmaceutical supplies</li></ul> <p>-Identify alternate sources of energy to maintain:</p> <ul style="list-style-type: none"><li>-Temperatures to protect resident health/safety</li><li>-Safe/sanitary storage of provisions</li><li>-Emergency lighting</li><li>-Fire detection, extinguishing, alarm systems</li><li>-Sewage and waste disposal</li></ul> <p>-Evidence the licensee developed P/P for system to track the location of on-duty staff and sheltered residents</p> <p>-Evidence the licensee developed P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the</p> | 0 680                                                                                           |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                           |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                     | <p>Continued From page 9</p> <p>specific name/location of the receiving facility or other location</p> <p>-Evidence the licensee developed P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance</p> <p>-Evidence the licensee developed P/P for shelter in place for residents, staff, and volunteers who remain in the facility</p> <p>-Evidence the licensee developed P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records</p> <p>-Evidence the licensee developed P/P to address: use of volunteers, including the process/role for integration</p> <p>-Evidence the licensee developed P/P to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act</p> <p>-Names and contact information of residents' physicians;</p> <p>-Evidence the licensee developed a communication plan to include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional &amp; local emergency management agencies</p> <p>-Evidence the licensee developed a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives</p> <p>On April 17, 2024, at 9:34 a.m., owner/house manager (O/HM)-C and owner/clinical nurse supervisor (O/CNS)-G stated they were aware of</p> | 0 680                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                     | Continued From page 10<br><br>the EPP content requirements and thought everything was covered in their EPP.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "Precious Lives Home will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                            | 0 680                                                                  |                                                                                                                          |  |                                                     |
| 0 780<br>SS=F                                                             | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(v) ensure the power supply for existing | 0 780                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                                     | <p>Continued From page 11</p> <p>smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.</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) 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).</p> <p>The findings include:</p> <p>On April 15, 2024, at 10:30 a.m., survey staff toured the home with owner/house manager (O/HM)-C and director of nursing (DON)-A. During the tour, survey staff observed when smoke alarms were tested none of the other smoke alarms in the home were activated. The smoke alarms installed in the dwelling unit were not interconnected. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was verified the smoke alarms were not interconnected. O-HM-C and DON-A stated this would be fixed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 780                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 790                                                                     | Continued From page 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 790                                                                                           |                                                                                                                          |  |                                                        |
| 0 790<br>SS=F                                                             | <p><b>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</b></p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.</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) 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).</p> <p>The findings include:</p> <p>On April 15, 2024, at 10:30 a.m., survey staff toured the home with owner/house manager (O/HM)-C and director of nursing (DON)-A.</p> | 0 790                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 790                                                                     | Continued From page 13<br><br>During the tour, survey staff observed tags or labels were not attached to the portable fire extinguishers showing annual maintenance inspections had been performed by certified service personnel. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was stated new fire extinguishers had been purchased and installed since the tour was completed on April 15, 2024. On April 23, 2024, the licensee emailed survey staff photos of fire extinguishers with maintenance inspection tags dated April 2024. The nurse evaluator was no longer on site to verify this installation.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                  | 0 790                                                                  |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                             | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be | 0 810                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                     | <p>Continued From page 14</p> <p>readily available at all times within the facility.<br/>(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.<br/>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.</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) 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).</p> <p>The findings include:</p> <p>On April 16, 2024, and April 18, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> | 0 810                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                                     | <p>Continued From page 15</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b><br/>The FSEP included an emergency preparedness policy dated August 1, 2021, and an emergency preparedness action plan without a date.</p> <p>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Employee actions for fire were limited to the acronyms RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) and PASS (Pull, Aim, Squeeze, Sweep).</p> <p>The FSEP did not identify fire protection procedures necessary for residents evident by limited instructions directing employees to move residents to a safe location.</p> <p>During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was verified the FSEP required revision.</p> <p>The FSEP failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including the unique needs of residents evident by a lack of these procedures in the plan. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was explained that residents received a priority classification for their needs during an evacuation. O/HM-C and DON-A stated currently there were residents living in the home who would require employee assistance during an evacuation.</p> <p><b>TRAINING</b><br/>Record review indicated the licensee failed to</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                           |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                     | <p>Continued From page 16</p> <p>provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. Two annual emergency preparedness action plan training records were provided, one dated 2023 and one dated 2024. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was stated employees were training on the FSEP as part of the emergency preparedness training and during fire drills, but this had not been documented separately. O/HM-C and DON-A explained new employees were trained on the FSEP at the time of hire and then at a frequency of twice per year. Records had not been created to document employee FSEP training.</p> <p>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. One annual emergency preparedness action plan training record was provided dated 2024 with three resident signatures identified. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, it was stated residents were trained on fire safety and evacuation as part of the emergency preparedness training, but this had not been documented separately. O/HM-C and DON-A explained residents participated during some of the employee fire drills and their names were recorded on the drill logs. Records had not been created to document resident training on fire safety and evacuation.</p> <p><b>DRILLS</b><br/>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required frequency. No fire drills were</p> | 0 810                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                                     | Continued From page 17<br><br>recorded in November 2023, December 2023, and January 2024. The time or shift was not recorded on the 2023 fire drill reports for April, May, and October. During an interview on April 23, 2024, at 1:05 p.m., with O/HM-C and DON-A, the fire drill frequency was verified, and it was stated if additional drill records were located these would be emailed to survey staff by the end of the day. Additional drill records were received, but none supported the evacuation drill frequency requirement of every other month had been met.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                     | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 0 970<br>SS=C                                                             | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a | 0 970                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 970                                                                     | <p>Continued From page 18</p> <p>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).</p> <p>The findings include:</p> <p>On April 16, 2024, at 12:40 p.m., the surveyor reviewed the licensee's blank contract which included the following waivers of liability on page 13:</p> <p>"Indemnification: Precious Lives Home shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or common [two words, not legible], and the resident agrees to hold Precious Lives Home harmless from any claims or damages unless caused solely by negligence of Precious Lives Home. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."</p> <p>"Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced."</p> <p>On April 17, 2024, at 9:34 a.m., owner/house manager (O/HM)-C and owner/clinical nurse supervisor (O/CNS)-G stated they were aware their contract could not have a waiver and did not</p> | 0 970                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 970                                                                     | <p>Continued From page 19</p> <p>realize they had waivers in theirs.</p> <p>On April 17, 2024, at 11:34 a.m., O/HM-C sent an email which included a page from their contract. The email indicated, "I checked the AL contract I gave you and it is the updated one that does not mention the liability part in the Miscellaneous Provision." The page provided was a duplicate of page 11 from the blank contract reviewed on April 16, 2024, which did not include waivers of liability. The waivers of liability were on page 13, the duplicate page 11 did not address the waivers of liability found on page 13 on April 16, 2024.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>                                                                                                                        | 0 970                                                                  |                                                                                                                          |  |                                                     |
| 01290<br>SS=I                                                             | <p><b>144G.60</b> Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced</p> | 01290                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                                     | <p>Continued From page 20</p> <p>by:<br/>Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee's health facility identification number (HFID) 34177 for two of 20 employees (registered nurse (RN)-E, unlicensed personnel (ULP)-F).</p> <p>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).</p> <p>The findings include:</p> <p>RN-E<br/>RN-E was hired on May 4, 2020, to provide direct cares, assessments, and oversight of unlicensed personnel. The licensee's Staff List dated April 15, 2024, indicated RN-E was originally hired on May 4, 2020, and then left the licensee on June 30, 2022. RN-E was rehired on April 9, 2024.</p> <p>RN-E received their nursing license on October 10, 2005, per the Minnesota Board of Nursing website. RN-E was licensed prior to January 1, 2018, and required a BGS to be completed by the licensee.</p> <p>RN-E's employee records lacked documentation of a completed BGS.</p> <p>ULP-F<br/>ULP-F was hired on October 26, 2018, to provide</p> | 01290                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                                     | <p>Continued From page 21</p> <p>direct care to residents.</p> <p>ULP-F's Final Registry Results form dated October 8, 2018, indicated it was completed for HFID 33838 and ULP-F was able to provide direct contact services for the agency named.</p> <p>ULP-F's Background Study Notice dated October 19, 2018, indicated it was completed for HFID 33838 and ULP-F was able to provide direct contact services for the agency named.</p> <p>The licensee's employee schedule for April 4-17, 2024, indicated ULP-F worked on the following dates:<br/>-April 5, 8, 9, 10, 2024.</p> <p>On April 15, 2024, at 11:25 a.m., the surveyor compared the licensee's NETStudy2.0 (a web-based system used to submit BGS requests to the Department of Human Services (DHS)) roster for HFID 34177 to the licensee's Staff List. The surveyor observed RN-E and ULP-F were not on the NETStudy2.0 roster. Owner/house manager (O/HM)-C searched for both RN-E and ULP-F by name in NETStudy2.0 but neither could be located. O/HM-C provided two BGS clearance letters (listed above) for ULP-F which were run under HFID 33838; they stated they were the only BGS records they had for ULP-F. HM-C stated HFID 33838 was their old HFID prior to the new assisted living regulations that went into effect on August 1, 2021. O/HM-C also stated they had run a BGS for RN-E under HFID 33838 and would provide it to the surveyor. The surveyor observed O/HM-C attempt to view HFID 33838 in NETStudy2.0 but O/HM-C was unable to access HFID 33838. O/HM-C stated they no longer had access to HFID 33838 in NETStudy2.0. Therefore, the licensee would not have means to</p> | 01290                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                                     | <p>Continued From page 22</p> <p>be notified in the event RN-E or ULP-F were disqualified by the Department of Human Services. O/HM-C stated the staff should have had BGS completed for the licensee's HFID 34177.</p> <p>On April 15, 2024, at 2:15 p.m., O/HM-C stated they called NETStudy2.0 and were told by NETStudy2.0 they could see HFID 33838 on their end, but O/HM-C no longer had access to it.</p> <p>On April 15, 2024, at 3:10 p.m., O/HM-C stated they again talked to NETStuday2.0 and were able to send them a copy of RN-E's original BGS completed under HFID 33838. O/HM-C stated they did not have a copy of it in RN-E's record.</p> <p>The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated policy revised on September 29, 2023, indicated:<br/>"4. The Criminal Background Check will be submitted to Minnesota Department of Human Services (OHS) following the step-by-step procedure established by OHS:<br/>i. The director or designee is responsible for initiating the criminal background study for new employees<br/>ii. NetStudy 2.0 (or current version) will be used for the background check<br/>iii. The employee will be directed to locations established by OHS to obtain fingerprint scans<br/>iv. Employees will be instructed that photographic identification will be required"</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> | 01290                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                                     | Continued From page 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 01500                                                                  |                                                                                                                          |  |                                                     |
| 01500<br>SS=F                                                             | <b>144G.63 Subd. 5 Required annual training</b><br><br>(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:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. | 01500                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                                     | <p>Continued From page 24</p> <p>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:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B).</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) 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).</p> <p>The findings include:</p> | 01500                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                                     | <p>Continued From page 25</p> <p>CNS-A<br/>CNS-A was hired on January 1, 2021, to provide oversight of ULPs, direct care services and assessments for residents.</p> <p>R1's Clinical Update Assessment (14-day assessment) dated May 22, 2023, indicated CNS-A completed the assessment.</p> <p>On April 15, 2024, the surveyor observed CNS-A performing their CNS duties throughout the day.</p> <p>CNS-A's employee record included a Rtask (charting software) Review of Policies - All Staff list, printed on April 16, 2024, which only included three pages of a 35-page document, listed the annual training topics reviewed, but lacked documentation of the number of hours spent on the training for the following required topics:<br/>-reporting maltreatment of vulnerable adults or minors;<br/>-assisted living bill of rights;<br/>-infection control techniques;<br/>-review of provider's policies and procedures; and<br/>-principles of person-centered planning/service delivery.</p> <p>CNS-A's employee record lacked documentation of the following annual training topics having been completed:<br/>-effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and<br/>-principles of person-centered planning/service delivery.</p> <p>ULP-B<br/>ULP-B was hired on February 9, 2023, to provide</p> | 01500                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                                     | <p>Continued From page 26</p> <p>direct care services to residents.</p> <p>On April 16, 2024, at 8:32 a.m., the surveyor observed ULP-B administering medications for R1.</p> <p>ULP-B's employee record included a Rtask (charting software) Review of Policies - All Staff list, printed on April 16, 2024, which only included two pages of a 35-page document, listed the annual training topics reviewed, but lacked documentation of the number of hours spent on each training for the following required topics:</p> <ul style="list-style-type: none"><li>-reporting maltreatment of vulnerable adults or minors;</li><li>-assisted living bill of rights;</li><li>-infection control techniques; and</li><li>-review of provider's policies and procedures.</li></ul> <p>ULP-B's employee record lacked documentation of the following annual training topics having been completed:</p> <ul style="list-style-type: none"><li>-Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and</li><li>-Principles of person-centered planning/service delivery.</li></ul> <p>On April 17, 2024, at 9:34 a.m., owner/house manager (O/HM)-C and clinical nurse supervisor (CNS)-G stated they were aware of annual training topics but didn't realize eight hours of training was required, they thought just covering the required topics would be enough. They stated they did not document the amount of time spent on annual trainings. Additionally, they stated they did not realize they did not assign all required training topics. O/HM-C and CNS-G stated it was</p> | 01500                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                                     | <p>Continued From page 27</p> <p>their responsibility to make sure annual trainings were completed. They stated they were not documenting the hours of training for any of their employee's annual training.</p> <p>The licensee's provided only one page of their 4.3 Staff Orientation and Education policy dated 2021, which indicated:<br/>"12.All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment.<br/>13. Education topics will include, but not be limited to, the following<br/>a. Reporting of maltreatment of adults"</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>                                                                                              | 01500                                                                  |                                                                                                                          |  |                                                     |
| 01530<br>SS=D                                                             | <p><b>144G.64 TRAINING IN DEMENTIA CARE REQUIRED</b></p> <p>(a) All assisted living facilities must meet the following training requirements:<br/>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br/>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial</p> | 01530                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34177</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01530                                                                     | <p>Continued From page 28</p> <p>eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide documentation for the number of hours completed for the two hours of required annual dementia training for one of two direct care employees (unlicensed personnel (ULP)-B).</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) 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>ULP-B was hired on February 9, 2023, to provide direct care services to residents.</p> <p>On April 16, 2024, at 8:32 a.m., the surveyor observed ULP-B administering medications for R1.</p> <p>ULP-B's employee record included a Rtask (charting software) Review of Policies - All Staff</p> | 01530                                                                                           |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                                     | <p>Continued From page 29</p> <p>list, printed on April 16, 2024, and only included two pages of a 35 page document. It indicated dementia training was completed on January 24, 2024, but lacked documentation of the number of hours spent on the required training.</p> <p>On April 17, 2024, at 9:34 a.m., owner/house manager (O/HM)-C and clinical nurse supervisor (CNS)-G stated they were aware of annual dementia training requirements but did not document the amount of time spent on the annual trainings. O/HM-C and CNS-G stated it was their responsibility to make sure annual trainings were completed.</p> <p>The licensee's Dementia Education policy dated August 1, 2021, indicated, "2. Supervisors of direct-care staff must have at least two (2) hours of education on topics related to dementia care for each twelve (12) months of employment thereafter." Further it indicated, "7. Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01530                                                                  |                                                                                                                          |  |                                                     |
| 02410<br>SS=F                                                             | <p>144G.91 Subd. 13 Personal and treatment privacy</p> <p>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 02410                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02410                                                                     | <p>Continued From page 30</p> <p>emergency or unless otherwise documented in the resident's service plan.</p> <p>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.</p> <p>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to support reasonable privacy during activities for toileting and bathing for all residents, staff, and visitors.</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) 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).</p> <p>The findings include:</p> <p>The facility was a two-level rambler style home with a main floor and a basement. There was a bathroom on the main level just outside of three</p> | 02410                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34177</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PRECIOUSLIVESHOMEVADNAISHEIGHT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SUZANNE AVENUE<br/>VADNAIS HEIGHTS, MN 55127</b>                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02410                                                                     | <p>Continued From page 31</p> <p>bedrooms and a second bathroom in the basement.</p> <p>On April 15, 2024, at 10:30 a.m., during the facility tour, the surveyor observed the main floor bathroom door which was a white barn style sliding door with a bar/pull handle and lacked a locking mechanism. The surveyor inquired if the door locked, owner/house manager (O/HM)-C stated, "no, does it need to be able to lock?"</p> <p>The licensee's Resident Confidentiality policy dated August 1, 2021, indicated, "All employees shall adhere to the Assisted Living Bill of Rights."</p> <p>The Minnesota Department of Health (MDH) Assisted Living Bill of Rights, last updated November 8, 2022, indicated, "Privacy must be respected during toileting, bathing and other activities of personal hygiene except as needed for resident safety or assistance."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 02410                                                                  |                                                                                                                          |  |                                                     |

Type: Full  
Date: 04/15/24  
Time: 12:00:00  
Report: 1031241100

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Preciousliveshomevadnaisheight  
60 Suzanne Avenue  
Vadnais Heights, MN55127  
Ramsey County, 62

**Establishment Info:**

ID #: 0038768  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6514688438  
ID #:

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

The following orders were issued during this inspection.

**4-300 Equipment Numbers and Capacities****4-302.14 \*\* Priority 2 \*\***

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.

Comply By: 04/18/24

**4-600 Cleaning Equipment and Utensils****4-601.11B**

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

OVEN INTERIOR HAS BUILDUP OF FOOD DEBRIS. CLEAN OVER INTERIOR.

Comply By: 05/06/24

**6-300 Physical Facility Numbers and Capacities****6-303.11C**

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

LIGHT IN RANGE HOOD IS BURNT OUT. REPLACE LIGHT.

Comply By: 05/06/24

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 at Degrees Fahrenheit

Location: Good & Clean Wipes

Violation Issued: No

Type: Full  
Date: 04/15/24  
Time: 12:00:00  
Report: 1031241100  
Preciousliveshomevadnaisheight

# Food and Beverage Establishment Inspection Report

Hot Water: = at 160 Degrees Fahrenheit  
Location: Dish Machine  
Violation Issued: No

## Food and Equipment Temperatures

Process/Item: Cold Hold/Refrigerator  
Temperature: 38 Degrees Fahrenheit - Location: Deli Ham  
Violation Issued: No

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

Inspection conducted by Chris F.

All violations discussed with Ren during the inspection.

## NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Employee food needs to be labeled and separated from residents food.
- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.
- Extra care should be taken when cleaning behind cabinet hardware so debris does not build up.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- 2-Comp sink has right basin designated for handwashing and the left basin for product washing/prep sink.
- When cooking food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full  
Date: 04/15/24  
Time: 12:00:00  
Report: 1031241100  
Preciousliveshomevadnaisheight

# Food and Beverage Establishment Inspection Report

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

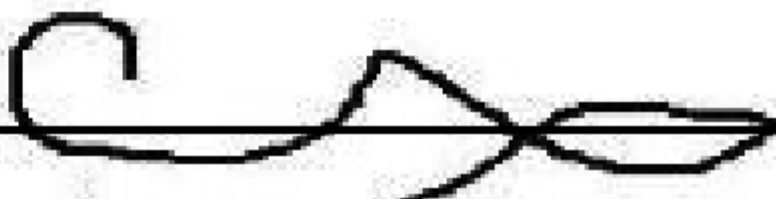
I acknowledge receipt of the Environmental Health inspection report number 1031241100 of 04/15/24.

Certified Food Protection Manager Reyman E. De Los Santos

Certification Number: FM111423 Expires: 05/13/25

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_  
Reneellen De Los Santos  
Person in Charge

Signed:  \_\_\_\_\_  
Chris Foster  
Public Health Sanitarian II  
Freeman Office Building  
651-983-8760  
chris.j.foster@state.mn.us

Report #: 1031241100

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

0

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

04/15/24

Time In

12:00:00

Time Out

Preciousliveshomevadnaisheight

Address

60 Suzanne Avenue

City/State

Vadnais Heights, MN

Zip Code

55127

Telephone

6514688438

License/Permit #

0038768

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUTPIC knowledgeable; duties & oversight

2

IN

OUTN/ACertified food protection manager, duties

Employee Health

3

IN

OUTMgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUTN/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUTN/OHands clean & properly washed

9

IN

OUTN/AN/A No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood obtained from approved source

12

IN

OUTN/AN/OFood received at proper temperature

13

IN

OUTFood in good condition, safe, & unadulterated

14

IN

OUTN/AN/OREquired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUTN/AN/OFood separated and protected

16

IN

OUTN/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

IN

OUT

N/A

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

IN

OUT

N/A

N/O

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

IN

OUT

N/A

N/O

Thermometers provided & accurate

Food Identification

37

IN

OUT

N/A

N/O

Food properly labled; original container

Prevention of Food Contamination

38

IN

OUT

N/A

N/O

Insects, rodents, & animals not present

39

IN

OUT

N/A

N/O

Contamination prevented during food prep, storage & display

40

IN

OUT

N/A

N/O

Personal cleanliness

41

IN

OUT

N/A

N/O

Wiping cloths: properly used & stored

42

IN

OUT

N/A

N/O

Washing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

IN

OUT

N/A

N/O

In-use utensils: properly stored

44

IN

OUT

N/A

N/O

Utensils, equipment & linens: properly stored, dried, & handled

45

IN

OUT

N/A

N/O

Single-use/single service articles: properly stored & used

46

IN

OUT

N/A

N/O

Gloves used properly

Utensil Equipment and Vending

47

IN

OUT

N/A

N/O

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

IN

OUT

N/A

N/O

XWarewashing facilities: installed, maintained, & used; test strips

49

IN

OUT

N/A

N/O

XNon-food contact surfaces clean

Physical Facilities

50

IN

OUT

N/A

N/O

Hot & cold water available; adequate pressure

51

IN

OUT

N/A

N/O

Plumbing installed; proper backflow devices

52

IN

OUT

N/A

N/O

Sewage & waste water properly disposed

53

IN

OUT

N/A

N/O

Toilet facilities: properly constructed, supplied, & cleaned

54

IN

OUT

N/A

N/O

Garbage & refuse properly disposed; facilities maintained

55

IN

OUT

N/A

N/O

Physical facilities installed, maintained, & clean

56

IN

OUT

N/A

N/O

XAdequate ventilation & lighting; designated areas used

57

IN

OUT

N/A

N/O

Compliance with MCIAA

58

IN

OUT

N/A

N/O

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 04/16/24

Inspector (Signature)