DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 9, 2022

Administrator
Prelude Homes & Services, LLC
10045 Antrim Court
Woodbury, MN 55129

RE: Project Number(s) SL31433015

Dear Administrator:

On February 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 2, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered
January 12, 2022

Administrator
Prelude Homes & Services LLC
10045 Antrim Court
Woodbury, MN 55129

RE: Project Number(s) SL31433015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 2, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31433	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	10045 ANTRIM COURT WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#31433015 On December 1 through December 2, 2021, 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 five (5) residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for five of five residents (R1, R2, R3, R4, R5) to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all five residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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).	0 460		

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0 460	Continued From page 2 The findings include: During the entrance conference on December 1, 2021, at approximately 9:30 a.m. licensed assisted living director (LALD)-A confirmed the facility did not have a call system in place for residents to request assistance when needed. LALD-A indicated four of five residents were able to ambulate independently and if they needed assistance they would leave the room to go and get staff for assistance; however, one of five residents (R4) recently had hip surgery. Each resident room lacked any type of call system to notify staff when assistance was needed. The licensee 24-Hour Emergency Response policy dated August 1, 2021, read "If the resident or their designated rep. requests a means by which for the resident to summon staff without them leaving their room or asking for help, a manual bell will be provided to the resident for use in their room". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	0 470		

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0 470	Continued From page 3 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location, potentially affecting the licensee's five current residents, staff and any visitors of the licensee. 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).	0 470		

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0 470	Continued From page 4 The findings include: The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: - Direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked. - The direct-care staff members resident assignments or work location. - Be posted after redacting direct-care staff members resident assignments, at the beginning of each work shift in a central location in each building. On December 1, 2021, at 9:35 a.m. the surveyor conducted a tour of the licensee's building. A staffing schedule was not posted in a central location. On December 1, 2021, at 9:40 a.m. licensed assisted living director (LALD)-A confirmed a staffing schedule was not posted in a central location and indicated the intent was to have a binder with the posting; however, there was no binder observed. The licensee's Public Postings policy dated August 1, 2021, indicated a daily staffing schedule would be posted in conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 5 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all five residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 1, 2021, for the specific	0 480		

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0 480	Continued From page 6 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all five residents	0 490		

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0 490	Continued From page 7 receiving assisted living services This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a program of daily social and recreational activities. During a tour of the facility on December 1, 2021, at 9:35 a.m. there was no calendar of recreational or social activities observed. On December 1, 2021, at 9:30 a.m. licensed assisted living director (LALD)-A confirmed there was no calendar of recreational or social activities. The licensee's Public Postings policy dated August 1, 2021, indicated the licensee would post a monthly activity calendar in a conspicuous location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 8 information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all five residents receiving assisted living services, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of posting in the common area	0 550		

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0 550	Continued From page 9 of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On December 1, 2021, during a facility tour at approximately 9:35 a.m. an observation of the facility's common areas noted the lack of the required posting of the grievance procedure and Ombudsman contact information. On December 1, 2021, at 9:40 a.m. licensed assisted living director (LALD)-A verified the required information was not posted in the common areas of the facility. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. The policy also indicated the posting would have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640		

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0 640	Continued From page 10 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required content in common areas to include: 911 emergency number in common areas and near telephones provided by the assisted living facility and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all five residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2021, at 9:40 a.m. an observation made of the facility main entry area	0 640		

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0 640	Continued From page 11 and common areas noted a lack of the following required information: - posting of 911 emergency number in common areas and near telephones provided by the assisted living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557 On December 1, 2021, at 9:40 a.m. licensed assisted living director (LALD)-A confirmed the required content noted above had not been posted as required. The licensee's Complaint /Grievance Posting policy dated August 1, 2021, indicated the licensee would post information for reporting suspected maltreatment to MAARC. The licensee lacked a policy regarding posting of 911 emergency numbers in common area and near telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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	31433	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	10045 ANTRIM COURT WOODBURY, MN 55129

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0 680	Continued From page 12 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to affect all five residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2021, at 9:45 a.m. the surveyor	0 680		

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0 680	Continued From page 13 conducted a tour of licensee's building. An emergency preparedness plan was not posted in a central location. On December 1, 2021, at 9:45 a.m. licensed assisted living director (LALD)-A confirmed the emergency preparedness plan was not posted in a central location. The licensee's Public Postings policy dated August 1, 2021, indicated the licensee would post the emergency preparedness plan in a conspicuous location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the required portable fire	0 790		

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0 790	Continued From page 14 extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45, Subd.2(a)(2). This had the potential to directly affect the safety of all five residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 2, 2021, between 9:20 a.m. and 10:20 a.m. survey staff toured the facility with the Director of Maintenance (DOM)-F about the required portable fire extinguishers. There were three portable fire extinguishers located with signage outside the doors to indicate their locations: - one installed inside the kitchen pantry; - one installed inside the closet of the hallway of the basement; and - one installed inside the mechanical room Based on observations, all three extinguishers had tags attached showing the annually serviced "6/2021"; however, monthly inspections had not been performed and recorded as required. DOM-F verified the findings as he stated he was not aware of the monthly inspections of extinguishers and had asked about information relating to the required monthly inspections. No further information was provided.	0 790		

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0 790	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide all contents of the required documentation on fire safety and evacuation plan, and the documentation on employee and resident training related to the fire safety and evacuation plan and procedures. This has the potential to directly affect the safety of all five residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2021, at approximately 10:20 a.m. survey staff asked for the facility fire safety and evacuation plan documentation, drills, and training records for review. The Director of Maintenance (DOM)-F indicated the requested documents were not on site, and he needed to go grab them from another facility. At 10:40 a.m. DOM-F returned with documentation for review and the following findings were noted. FIRE SAFETY and EVACUATION PLANS: 1. Lack of specific procedures for employee fire safety and evacuation procedures necessary for the residents including procedures for their movements, and relocation during a fire or	0 810		

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0 810	Continued From page 17 similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair bound and needing assistance during evacuation. In addition, the documentation of the fire safety and evacuation plan lacked details on a meeting location during an evacuation. 2. No resident fire safety procedures. 3. The fire safety and evacuation plan and procedures were not readily available at the facility. TRAINING and RECORDS 1. No documented policy on required training of residents annually who are capable of assisting their own evacuation on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 2. No documented policy on required training of employees upon hire and twice a year thereafter, on fire safety and evacuation. 3. No documented records to show required training of employees on fire safety and evacuation plan has been performed. Fire safety and evacuation plans must be established and readily available at all times within the facility. Employees are required to complete performed training. Failure to provide the complete evacuation plan, training and drills can cause confusion and delay response time for evacuation of residents and employees during a fire or emergency. On December 2, 2021, at approximately 11:35	0 810		

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0 810	Continued From page 18 a.m. staff discussed the above findings, licensed assisted living director (LALD)-A and DOM-F acknowledged the findings listed above as they both explained that the residents were high functioning and able to self assist in evacuations, and the facility had been providing the training, but they will improve on their plans and documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900		

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0 900	Continued From page 19 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract to include all required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Assisted Living Contract dated August 17, 2021, lacked a witness signature and date by the provider. The contract also lacked the license number of the provider and the name of a designated representative that could assist R1. On December 1, 2021, at 1:50 p.m. R1 was	0 900		

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0 900	Continued From page 20 interviewed in his room and indicated his brother was his designated representative. R1's brother was also present for the interview. On December 2, 2021, at 12:15 p.m. licensed assisted living director (LALD)-A confirmed R1's assisted living contract lacked a witness signature and date by the provider, the license number of the provider and also the name of the designated representative that assisted R1. The licensee's undated Assisted Living Contract Table of Contents indicated the contract would include the license number of the building, the resident representatives and signatures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 21 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation in all required orientation topics for two of two unlicensed personnel (ULP-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C had a hire date of February 20, 2017. ULP-D had a hire date of February 18, 2020. Both employee records lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144.G; and -Review of the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 2, 2021, at 10:15 a.m. licensed assisted living director (LALD)-A confirmed not all employees had completed the above listed required orientation topics. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1,	01470		

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01470	Continued From page 23 2021, indicated all employees must complete the orientation to assisted living requirements before providing assisted living services to residents. The policy also indicated the orientation topics would include: -An overview of the appropriate Assisted Living statutes and rules. -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. This has the potential to	02040		

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02040	Continued From page 24 directly affect all dementia care residents. 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). The findings include: On December 2, 2021, at approximately 11:35 a.m. survey staff received a electronic copy of the "Hazard and Vulnerability Assessment Tool" on emergency hazard on natural, technological, human, and hazardous material from licensed assisted living director (LALD)-A. Based on document review, there was no evidence of a complete hazard vulnerability assessment to specifically addressing hazard vulnerabilities on and around the property including, no evidence of the mitigation plan documented to provide safety measures for the residents from harm for those hazards assessed on and around the property. On December 2, 2021, at approximately 11:45 a.m. staff discussed and confirmed the above findings with LALD-A, the Director of Maintenance (DOM)-F, and chief operations officer (COO)-B. COO-B further asked about the flexibility of not securing the laundry room and sharp tools and utensils in the kitchen when the facility consisted of high functioning residents with more independence, and were interested in engaging with household work which included assisting with cooking. Survey staff explained that the facility was responsible for developing the hazard and mitigation plan that was appropriate	02040		

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02040	Continued From page 25 to prevent harm to their residents, and mitigation can be managed based on the clinical needs and stage of the residents. Staff also clarified that the hazard vulnerability assessment plan must be reviewed and updated frequently and/or annually as to reflect the residents particular needs and stage of cognitive disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *12/01/21*
Time: 10:16:26
Report: 1023211283

Food and Beverage Establishment Inspection Report

Location:
Prelude Homes & Services Llc
10045 Antrim Court
Woodbury, MN55129
Washington County, 82

Establishment Info:
ID #: 0038143
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515016516
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED RAW ANIMAL FOODS SUCH AS SHELL EGGS STORED ABOVE RTE FOODS SUCH AS CHEESE. OPERATOR MOVED EGGS TO SAFE LOCATION. *CORRECTED ON SITE

Comply By: 12/01/21

2-100 Supervision

2-102.12FMN

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.

CFPM POSTED BUT OPERATOR STATED CFPM IS NOT INVOLVED IN DAILY FOOD PREPARATION. A PERSON INVOLVED IN DAY TO DAY FOOD OPERATIONS SHOULD BECOME CERTIFIED AS A CFPM.

Comply By: 12/01/21

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: NSF/ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 34 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Freezer/ALL ITEMS
Temperature: FROZEN Degrees Fahrenheit - Location: REACH IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF HEATHER ALLEN, THE PERSON IN CHARGE, AND ANGELA RICHEY (HRD NURSE EVALUATOR). ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- SAME DAY SERVICE REQUIRED
- SERVING HIGH RISK POPULATIONS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- HIGH RISK POPULATION REQUIREMENTS
- CFPM APPLICATION

YOU CAN SIGN UP FOR FOOD MANAGER COURSES HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Type: Full
Date: *12/01/21*
Time: 10:16:26
Report: 1023211283
Prelude Homes & Services Llc

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 Minnesota Department of Health inspection report number 1023211283 of 12/01/21.

Certified Food Protection Manager: HEATHER ALLEN

Certification Number: 69962 Expires: 08/15/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

HEATHER ALLEN
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us