



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 30, 2025

Licensee
Prelude Homes And Services
10018 Raleigh Road
Woodbury, MN 55129

RE: Project Number(s) SL34601016

Dear Licensee:

On May 8, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 7, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessie Chenze'.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

April 3, 2025

Licensee
Prelude Homes & Services, LLC
10018 Raleigh Road
Woodbury, MN 55129

RE: Project Number(s) SL34601016

Dear Licensee:

Please note: This letter amends the previous letter dated April 2, 2025, notifying you of survey results. Specifically, the immediate order for tag 2310 was rescinded and reissued at a Level 2, with a time period of correction that is not immediate. As a result of the corrected scope and level, which carries no immediate penalty, fine description for tag 2310 was removed from this letter and the total amount assessed was corrected.

The Minnesota Department of Health (MDH) completed a survey on March 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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.

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 or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER PRELUDE HOMES AND SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 10018 RALEIGH ROAD 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 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: SL34601016-0 On March 3, 2025, through March 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 47 residents; all whom received services under the Assisted Living Facility with Dementia Care license. An immediate correction order was issued for tag identification 1290 on March 7, 2025. During the course of the survey, the licensee took action to mitigate the immediate risk. Non compliance remained and the scope and level remain unchanged. During supervisory review, an additional immediate order for tag identification 2310 was identified. On April 3, 2025, the immediate order for tag identification 2310 was rescinded and reissued at	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful employee record information during the survey for one of two employees (life enrichment coordinator (LEC)-G). 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: On March 3, 2025, at 10:30 a.m., during the entrance conference, director of	0 330			

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0 330	Continued From page 2 operations/interim licensed assisted living director (DO/LALD)-A and licensed assisted living director (LALD)-C stated the licensee provided daily program of social and recreational activity, and their activities coordinator recently transferred here from another sister facility. They were aware of the required contents of the employee records and employee records were stored electronically and in paper format. DO/LALD-A stated any employee record requests would be provided via electronic mail. During observations on March 4, 2025, between 10:05 a.m.-10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity to a few residents. During interview at 10:40 a.m., LEC-G stated this was her second day at this location and LEC-G worked at the sister facility prior to this location. The licensee's employee roster dated March 3, 2025, did not list LEC-G as a current employee. On March 5, 2025, at 11:39 a.m., the surveyor sent an email to DO/LALD-A, requesting an updated employee roster to include contact information and date of hire for LEC-G and assistant director of clinical services (ADCS)-D. On March 5, 2025, at 11:54 a.m., the surveyor received an email indicating LEC-G began employment with licensee on May 13, 2024. On March 5, 2025, at 12:20 p.m., the surveyor sent an email to DO/LALD-A, requesting a background study clearance letter and tuberculosis screening for LEC-G.	0 330			

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0 330	Continued From page 3 LEC-G's Final Registry Results Form dated January 7, 2025, indicated a background study was initiated for health facility identification number (HFID) 32276 (the licensee's sister facility), but required LEC-G to be fingerprinted for study completion. On March 5, 2025, at 3:01 p.m., via email, DO/LALD-A provided a background study notice under HFID 34601 (the licensee's HFID) dated January 14, 2025, indicating LEC-G was cleared. During phone interview on March 6, 2025, at 8:45 a.m., LEC-G stated her work schedule was 9:00 a.m. to 5:00 p.m., and she began work at the licensee's facility on Monday, March 3, 2025. LEC-G stated her role included one on one activities with residents, coordinating large group activities, and helping observe/monitor changes in residents and reporting those changes to the nurse. LEC-G stated she was never instructed to get fingerprinted. On March 6, 2025, at 2:43 p.m., during phone interview, DO/LALD-A stated she had resubmitted a background study on LEC-G to "cover their bases." The surveyor asked when LEC-G was background checked in January 2025, did LEC-G require fingerprinting? DO/LALD-A stated, "I don't think so." On March 6, 2025, at 6:19 p.m., Department of Human Services representative (DHSR)-N stated, via email, LEC-G did not have a background study clearance for 34601. DHSR-N stated LEC-G only had a background study submitted by HFID 32276 on January 7, 2025, but was never fingerprinted, so the background study was closed, and LEC-G was removed from the	0 330			

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0 330	Continued From page 4 licensee's roster on January 22, 2025. DHSR-N further stated it appeared the clearance letter for LEC-G dated January 14, 2025, was originally issued to someone else and subsequently edited to insert LEC-G's name, address, a date, and the application number associated with the study from 32276 in place of a background study number. During interview on March 7, 2025, at 10:37 a.m., DO/LALD-A stated business office manager (BOM)-J was the licensee's designated sensitive information person (SIP) for all facilities and responsible for conducting background studies on all new hires. If a new hire required fingerprinting, they could begin orientation but could not be in contact with residents until BOM-J received the clearance notification from DHS, then BOM-J or staffing manager (SM)-M assisted with coordinating the remaining training with the facility's LALD. DO/LALD-A was not aware BOM-J received LEC-G's removal letter from DHS and assumed LEC-G was cleared to work because she was not told otherwise. To fix the issue, DO/LALD-A stated LEC-G's background study was initiated again and was scheduled to get fingerprinted. LEC-G was removed from the schedule and was no longer working until the clearance was received. During interview on March 7, 2025, at 12:04 p.m., BOM-J stated she had been trained to complete background studies and was the person responsible for completing the studies. The surveyor asked where the clearance letter dated January 14, 2025, which was originally issued to someone else and edited to insert LEC-G's name, address, date and the application number came from, BOM-J stated she wasn't sure but DO/LALD-A provided the document to the	0 330			

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0 330	Continued From page 5 surveyor. She said DO/LALD-A had access to the letter because when DO/LALD-A requested the clearance letter BOM-J was busy so DO/LALD-A was instructed to retrieve it. BOM-J also explained that all LALD's had access to all employee records because often they fill in for other sites. During phone interview on March 7, 2025, at 12:30 p.m., the surveyor asked DO/LALD-A how a clearance letter for this facility was available when there was no evidence a background study was initiated for HFID 34601? DO/LALD-A stated, "I do not really know, I thought it looked weird but printed it out anyway." She also stated it was not in the PDF file format like it usually was. The surveyor asked if the clearance letter was edited to look original, DO/LALD-A stated, "no idea," and could not explain further. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480			

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0 480	Continued From page 6 CFFM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480			

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660			

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0 660	Continued From page 8 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (life enrichment coordinator (LEC)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A and licensed assisted living director (LALD)-C stated upon hire, all staff filled out the history and symptom screen and completed the two-step skin TST on site.	0 660			

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0 660	Continued From page 9 The Facility TB Risk Assessment for North campus completed on July 4, 2024, indicated the facility was at a low risk for TB transmission. LEC-G was hired May 13, 2024, to provide memory care residents with social activities and engagement at the licensee's sister facility under health facility identification number (HFID) 32276. On March 3, 2025, LEC-G began working in the same role for the licensee's HFID 34601 (North campus). LEC-G's record included a Baseline TB Screening Tool for Health Care Workers file dated May 17, 2024, which include a TB history and symptom screen, and one negative TST completed on May 19, 2024. LEC-G's record lacked documentation of a required second TST. During observations on March 4, 2025, between 10:05 a.m. and 10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity to a few residents. On March 5, 2025, at 3:14 p.m., via email, DO/LALD-A stated the licensee's clinical team failed to implement a second TST per protocol. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated all health care workers would receive a baseline TB screening upon hire using a two-step TST or single blood test to test for TB, and the results would be maintained in the employee's medical record.	0 660			

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(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
0 660	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions has the ability to affect all staff and 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, 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). Findings include: On facility tour with the director of operations/interim licensed assisted living director (DO/LALD)-A, licensed assisted living director (LALD)-C and maintenance technician (MT)-E on March 4, 2025, between 08:30 a.m. and 12:00 p.m., the following deficient conditions were observed:	0 775			

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0 775	Continued From page 11 ELECTRICAL: The surveyor observed an open junction electrical box on the ceiling in the mechanical room and a white extension cord was plugged into a refrigerator in the nurse's office in the 10020 building. The surveyor observed a green extension cord plugged into a power strip in the office in the 10018 building. All open electrical boxes shall have a cover on them. Extension cords shall not be used for permanent use. KITCHEN HOOD PROTECTION SYSTEM: The surveyor observed the kitchen hood protection system had a non-compliant red tag on the system. Further review of the annual inspection report showed that the 12-year hydro test was due for the system in the 10020 building. The listed deficiency on the annual report shall be fixed. FIRE RATED DOORS/WALL: The surveyor observed a hole cut in the corridor wall and fan installed from a mechanical/IT room. Also, there were a few doors that had their closers removed. (kitchen/storage room) These were all in the 10020 building. The opening in the rated wall shall be closed or a code compliant fire damper installed. The closers shall be installed and these doors shall be kept closed at all times.	0 775			

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0 775	Continued From page 12 LOCKS: The surveyor observed hasp style locks on the two back doors to the courtyard in the 10020 building. These locks shall be removed. CARBON MONOXIDE PROTECTION: The surveyor observed no carbon monoxide protection in the 10018 building. Carbon monoxide protection shall be provided. The deficient conditions were visually verified by the DO/LALD-A, LALD-C and MT-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
01290 SS=G	144G.60 Subdivision 1 Background studies required (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. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290			

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01290	Continued From page 13 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed for one of two employees (life enrichment coordinator (LEC)-G). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated DO/LALD-A was aware of the required contents of employee records. LEC-G was hired May 13, 2024, to provide memory care residents with social activities and engagement at the licensee's sister facility under health facility identification number (HFID) 32276. On March 3, 2025, LEC-G began working in the same role for the licensee's HFID 34601. The licensee's Department of Human Services (DHS) NETStudy 2.0 Roster for HFID 34601 provided by licensee on March 3, 2025, indicated LEC-G lacked a completed background study.	01290	During the course of the survey, the licensee took action to mitigate the immediate risk. Non compliance remained and the scope and level remain unchanged.		

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01290	Continued From page 14 During observations on March 4, 2025, between 10:05 a.m.-10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity to a few residents. During interview at 10:40 a.m., LEC-G stated this was her second day at this location and LEC-G worked at the sister facility prior to this location. LEC-G's Final Registry Results Form dated January 7, 2025, indicated a background study was initiated for HFID 32276 (the licensee's sister facility), but required LEC-G to be fingerprinted for study completion. On March 5, 2025, at 3:01 p.m., via email, DO/LALD-A provided a background study notice under HFID 34601 dated January 14, 2025, indicating LEC-G was cleared. A NETStudy 2.0 screenshot dated March 6, 2025, at 8:07 a.m., indicated the only background study performed for LEC-G was for HFID 32276 on January 7, 2025. The screenshot also indicated LEC-G was listed as separated from HFID 32276 on January 22, 2025, and LEC-G was to be removed from direct patient care. The screenshot indicated LEC-G's NETStudy 2.0 profile lacked evidence of any additional background studies submitted for LEC-G under HFID 34601. During phone interview on March 6, 2025, at 8:45 a.m., LEC-G stated her work schedule was 9:00 a.m. to 5:00 p.m. and she began work at this facility on Monday, March 3, 2025. LEC-G stated her role included one on one activities with residents, coordinating large group activities, and	01290			

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01290	Continued From page 15 helping observe/monitor changes in residents and reporting those changes to the nurse. LEC-G stated she was never instructed to get fingerprinted. On March 6, 2025, at 2:43 p.m., during phone interview, DO/LALD-A stated she had resubmitted a background study on LEC-G to "cover their bases." The surveyor asked when LEC-G was background checked in January 2025, did LEC-G require fingerprinting? DO/LALD-A stated, "I don't think so." On March 6, 2025, at 6:19 p.m., Department of Human Services representative (DHSR)-N stated, via email, LEC-G did not have a background study clearance for 34601. DHSR-N stated LEC-G only had a background study submitted by HFID 32276 on January 7, 2025, but was never fingerprinted, so the background study was closed, and LEC-G was removed from the licensee's roster on January 22, 2025. DHSR-N further stated it appeared the clearance letter for LEC-G dated January 14, 2025, was originally issued to someone else and subsequently edited to insert LEC-G's name, address, a date, and the application number associated with the study from 32276 in place of a background study number. During phone interview on March 7, 2025, at 10:37 a.m., DO/LALD-A stated business office manager (BOM)-J completed background studies for all new hires. DO/LALD-A stated to ensure compliance, DO/LALD-A and BOM-J attempted to audit all employee records twice annually. On March 7, 2025, at 12:04 p.m., during phone interview, BOM-J explained the licensee was in the middle of going through software changes	01290			

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01290	Continued From page 16 and had been busy dealing with that. BOM-J stated she used a checklist and set reminders to ensure tasks were completed. BOM-J was not sure if LEC-G completed fingerprinting and stated she did not have a reminder to follow up on that requirement. The licensee's 4.02 Background Studies policy dated May 3, 2023, indicated the community will conduct a Minnesota DHS Background Study on all staff of community who will have independent, unsupervised contact with tenants or residents of community. No employee may have independent direct contact with any tenants or residents until acceptable result of the background study have been received. The community will not employ individuals whose results of the background study indicate disqualification for the position. The BOM would conduct quarterly audits to ensure all staff have cleared background studies. The NETStudy 2.0 System User Manual updated July 7, 2023, indicated on page 50: Fingerprint Deadline- study subjects who are required to be fingerprinted and photographed in most cases have 14 calendar days from the date the study is submitted to complete the process. NETStudy 2.0 users receive email notifications reminding them when a study subject is required to be fingerprinted but has not yet completed the process. Entities are responsible to ensure study subjects are fingerprinted by the deadline. If not, the background study application will close and the entity must submit a new application. The NETStudy 2.0 System User Manual also indicated on page 54: Supervision Status defined as Remove - the study subject must be removed from any position that requires a DHS background study.	01290			

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01290	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, upon a change in	01620			

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01620	Continued From page 18 condition (CIC) for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated assistant director of clinical services (ADCS)-D was the interim primary nurse as the former RN, RN-P's, last day was on January 3, 2025. ADCS-D worked on site one day a week and was on-call. DO/LALD-A stated RNs completed pre-admission assessment, face to face assessment upon admission, 14-day and 90-day assessments, and a CIC assessment such as a post hospitalization. R4 admitted on October 15, 2024, and had diagnoses of memory impairment, major cognitive disorder impaired gait mobility, and depression. R4's 14-day assessment completed by RN-P on October 24, 2024, indicated the following: -bed mobility: independent; -transfers: stand by assist due to unsteadiness; -ambulation: independent; -bed safety: standard bed type; -nutrition assistance: independent; and -evacuation acuity level: level 2-resident who is	01620			

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01620	Continued From page 19 ambulatory requires moderate nursing care and requires moderate assistance with evacuation. R4's nurse note by licensed practical nurse (LPN)-O dated October 30, 2024, indicated R4 had an x-ray on his left foot due to tissue swelling and a request was sent to provider requesting to reduce medications. Provider inquired about hospice (end of life care) as LPN-O indicated R4 required a wheelchair, total lift for transfers, and feeding assistance. R4's nurse note by LPN-O dated November 8, 2024, indicated R4 was admitted to hospice and a hospital bed, Hoyer lift (full body mechanical lift), and wheelchair were being delivered. Medication changes made and comfort pack medications would be delivered (medications that provide end of life comfort). R4's most recent 90-day assessment completed by RN-P dated January 2, 2025, was nearly identical to the 14-day assessment despite the documented observed changes made by LPN-O. The assessment included the same information: -bed mobility: independent; -transfers: stand by assist due to unsteadiness; -ambulation: independent; -bed safety: standard bed type; -nutrition assistance: independent; and -evacuation acuity level: level 2-resident who is ambulatory requires moderate nursing care and requires moderate assistance with evacuation. R4's Service Plan-Private Pay-MN signed February 3, 2025, indicated R4 required total assistance with dressing and grooming, repositioning, meals, daily inspection of Halo side rails by ULP, and assist of two staff using full body transfer using the Hoyer. The service plan	01620			

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01620	Continued From page 20 was signed by LPN-O. R4's record lacked a change in condition assessment following a significant physical decline and admission to hospice service requiring multiple medication changes. During observation on March 4, 2025, at 12:42 p.m., R4 was sitting in a Broda chair (oversized padded wheelchair) in the dining room receiving feeding assistance by ULP-H. On March 4, 2025, at 1:02 p.m., ULP-H and ULP-I transferred R4 from the Broda chair to the bed using the Hoyer lift. Due to R4's height, both ULPs scooted R4 up into bed because his feet were touching the foot board of the bed. Both ULP's rolled R4 side to side to remove the body sling underneath and during that time R4 became resistive and yelled. During interview on March 4, 2024, at 2:39 p.m., LPN-O stated she managed medications, processed orders, communicated with providers and communicated with resident and their families. LPN-O stated ADCS-D had been the interim nurse and would come do assessments and helped with training. LPN-O explained R4 came in walking but now required two-person assist with Hoyer transfers. At the time of R4's admission, LPN-O stated she was on vacation, then in a week or two, he declined which the provider performed several different types of tests to find the cause of the decline but found nothing, so he was admitted to hospice care. During phone interview on March 5, 2025, at 1:13 p.m., ADCS-D stated she completed CIC assessments when there was a change in function such as transfers, meal assistance, or a	01620			

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01620	Continued From page 21 deviation from the person's baseline. She also stated she would complete a CIC assessment upon admission to hospice care. ADCS-D stated when R4 was admitted to hospice, RN-P was working at the time so the assessment should have been completed by RN-P. The licensee's 6.01 Assessments, Reviews & Monitoring policy last revised September 5, 2024, indicated ongoing reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for use of consumer side rails for two of two residents (R4, R2). This practice resulted in a level two violation (a	02310			

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02310	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on March 3, 2025, at 11:04 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated both cottages (10018 and 10020) included memory care residents, and they tried not to have side rails but there were two families that insisted they have them. She said the licensee would obtain signed waivers and received provider orders to use side rails. Nursing related questions on side rail assessments were directed to interim assistant director of clinical services (ADCS)-D. R4 During observation on March 4, 2025, at 12:42 p.m., the surveyor observed R4's hi/low bed with two Halo side rails (round metal grab bar affixed to a hi/low bed) one on each side of the bed. The Halos were secured to the bed frame. On March 4, 2025, at 1:02 p.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-I transfer R4 into bed using full body transfer using mechanical lift (Hoyer). While turning side to side while in bed, R4 grabbed the Halo side rails to assist. R4 admitted on October 15, 2024, and had diagnoses of memory impairment, major cognitive disorder impaired gait mobility, and	02310			

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02310	Continued From page 23 depression. R4's Service Plan-Private Pay-MN signed February 3, 2025, indicated R4 required total assistance with dressing and grooming, repositioning, meals, daily inspection of Halo side rails by ULP, and assist of two staff using full body transfer using the Hoyer. R4's medical record included a provider order to utilize Halo side rails and risk vs benefit verbally signed by R4's designated representative on December 3, 2024, and December 4, 2024, respectively. R4's most recent quarterly nursing assessment dated January 2, 2025, indicated R4 utilized a standard bed and did not indicate he used side rails. R4's medical record lacked: -an RN assessment of the resident's cognitive and physical status as they pertain to the side rail; -documentation of physical inspection of side rails and mattress for areas of entrapment, stability, and correct installation; and -documentation of having checked the Consumer Product Safety Committee (CPSC) for any recalls. R2 R2 admitted on January 27, 2025, and had diagnoses of dementia, chronic kidney disease, and diabetes. On March 4, 2025, at 10:45 a.m., during interview with R2's family member (FM)-L, the surveyor observed two Halo siderails on both sides of the bed. The Halo's were secured to the bed frame.	02310			

Minnesota Department of Health

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02310	Continued From page 24 R2's Service Plan-Private Pay-MN signed January 27, 2025, indicated R2 received assistance with bathing, dressing and grooming, mobility, hearing aids, and daily inspection of Halo side rails by ULP. R2's medical record included a risk vs benefit consent form signed on January 27, 2025. R2's 14-day nursing assessment dated February 10, 2025, indicated R2 utilized a halo device on the side of her bed. R2's medical record lacked: -documentation of physical inspection of side rails and mattress for areas of entrapment, stability, and correct installation; and -documentation of having checked the Consumer Product Safety Committee (CPSC) for any recalls. During interview on March 4, 2025, at 2:39 p.m., licensed practical nurse (LPN)-O stated if families insisted on having side rails, she obtained provider orders for side rails, ensured they were listed in the service plan, and physically checked the side rails and made sure the residents were capable of using them. LPN-O believed the side rails were assessed by the registered nurse but did not know how often they completed side rail assessments. During phone interview on March 5, 2025, at 11:15 a.m., ADCS-D explained she was not provided training by licensee on how to complete side rail assessments but utilized her previous experience by obtaining provider's orders, and discussed risk vs benefits of having a side rail. ADCS-D stated it was her process to ensure the side rails were installed properly and secured to	02310			

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02310	Continued From page 25 the bed frame, make sure residents were using it properly. She was not aware of checking for recalls and did not have a manual available to reference. When R2 was admitted, ADCS-D stated she did not see the Halo on the bed but knew there was one based on interview with the resident and resident's designated representative. It was her practice to physically check the side rails and ensure proper use of them every 90 days. ADCS-D stated there was a new nurse starting that week so she was optimistic the new nurse would teach her all of the requirements. Regarding R4's most recent assessment, ADCS-D stated the former registered nurse (RN)-P was still working so she had no involvement with R4's side rails. The Food and Drug Administration (FDA) Bed Rail Safety Activities document, dated February 27, 2023, included, "The FDA and Consumer Product Safety Commission (CPSC) have worked with manufacturers, health care practitioners, and consumer representatives to develop a voluntary consensus standard that applies to all adult portable adult bed rails, whether they are regulated by the FDA or the CPSC, to assure there are no gaps in federal oversight of the safety of these products. ASTM F3186-17: Standard Specification for Adult Portable Bed Rails and Related Products was published in 2017 and is recognized by the FDA. This standard establishes performance criteria for adult portable bed rails including resistance to entrapment." The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The	02310			

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02310	Continued From page 26 FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health's (MDH) Assisted Living: Resources and FAQ's website last updated on December 13, 2024, read under Consumer bed rails, that licensees should ensure, "an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, included "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's 6.28 Side rails policy revised December 3, 2024, indicated the licensee would assess the use, educate the resident or the	02310			

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02310	Continued From page 27 responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy also indicated the registered nurse would gather all pertinent data to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The policy lacked procedures for checking side rail recalls. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2025

Licensee

Prelude Homes & Services, LLC

10018 Raleigh Road

Woodbury, MN 55129

RE: Project Number(s) SL34601016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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.

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', followed by a horizontal line.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
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0 000	Initial Comments 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: SL34601016-0 On March 3, 2025, through March 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 47 residents; all whom received services under the Assisted Living Facility with Dementia Care license. An immediate correction order was issued for tag identification 1290 on March 7, 2025. During the course of the survey, the licensee took action to mitigate the immediate risk. Non compliance remained and the scope and level remain unchanged. During supervisory review, an additional immediate order for tag identification 2310 was identified.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility	0 330			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful employee record information during the survey for one of two employees (life enrichment coordinator (LEC)-G). 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: On March 3, 2025, at 10:30 a.m., during the entrance conference, director of operations/interim licensed assisted living director (DO/LALD)-A and licensed assisted living director (LALD)-C stated the licensee provided daily program of social and recreational activity, and their activities coordinator recently transferred here from another sister facility. They were aware	0 330			

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0 330	Continued From page 2 of the required contents of the employee records and employee records were stored electronically and in paper format. DO/LALD-A stated any employee record requests would be provided via electronic mail. During observations on March 4, 2025, between 10:05 a.m.-10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity to a few residents. During interview at 10:40 a.m., LEC-G stated this was her second day at this location and LEC-G worked at the sister facility prior to this location. The licensee's employee roster dated March 3, 2025, did not list LEC-G as a current employee. On March 5, 2025, at 11:39 a.m., the surveyor sent an email to DO/LALD-A, requesting an updated employee roster to include contact information and date of hire for LEC-G and assistant director of clinical services (ADCS)-D. On March 5, 2025, at 11:54 a.m., the surveyor received an email indicating LEC-G began employment with licensee on May 13, 2024. On March 5, 2025, at 12:20 p.m., the surveyor sent an email to DO/LALD-A, requesting a background study clearance letter and tuberculosis screening for LEC-G. LEC-G's Final Registry Results Form dated January 7, 2025, indicated a background study was initiated for health facility identification number (HFID) 32276 (the licensee's sister facility), but required LEC-G to be fingerprinted	0 330			

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0 330	Continued From page 3 for study completion. On March 5, 2025, at 3:01 p.m., via email, DO/LALD-A provided a background study notice under HFID 34601 (the licensee's HFID) dated January 14, 2025, indicating LEC-G was cleared. During phone interview on March 6, 2025, at 8:45 a.m., LEC-G stated her work schedule was 9:00 a.m. to 5:00 p.m., and she began work at the licensee's facility on Monday, March 3, 2025. LEC-G stated her role included one on one activities with residents, coordinating large group activities, and helping observe/monitor changes in residents and reporting those changes to the nurse. LEC-G stated she was never instructed to get fingerprinted. On March 6, 2025, at 2:43 p.m., during phone interview, DO/LALD-A stated she had resubmitted a background study on LEC-G to "cover their bases." The surveyor asked when LEC-G was background checked in January 2025, did LEC-G require fingerprinting? DO/LALD-A stated, "I don't think so." On March 6, 2025, at 6:19 p.m., Department of Human Services representative (DHSR)-N stated, via email, LEC-G did not have a background study clearance for 34601. DHSR-N stated LEC-G only had a background study submitted by HFID 32276 on January 7, 2025, but was never fingerprinted, so the background study was closed, and LEC-G was removed from the licensee's roster on January 22, 2025. DHSR-N further stated it appeared the clearance letter for LEC-G dated January 14, 2025, was originally issued to someone else and subsequently edited to insert LEC-G's name, address, a date, and the application number associated with the study	0 330			

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0 330	Continued From page 4 from 32276 in place of a background study number. During interview on March 7, 2025, at 10:37 a.m., DO/LALD-A stated business office manager (BOM)-J was the licensee's designated sensitive information person (SIP) for all facilities and responsible for conducting background studies on all new hires. If a new hire required fingerprinting, they could begin orientation but could not be in contact with residents until BOM-J received the clearance notification from DHS, then BOM-J or staffing manager (SM)-M assisted with coordinating the remaining training with the facility's LALD. DO/LALD-A was not aware BOM-J received LEC-G's removal letter from DHS and assumed LEC-G was cleared to work because she was not told otherwise. To fix the issue, DO/LALD-A stated LEC-G's background study was initiated again and was scheduled to get fingerprinted. LEC-G was removed from the schedule and was no longer working until the clearance was received. During interview on March 7, 2025, at 12:04 p.m., BOM-J stated she had been trained to complete background studies and was the person responsible for completing the studies. The surveyor asked where the clearance letter dated January 14, 2025, which was originally issued to someone else and edited to insert LEC-G's name, address, date and the application number came from, BOM-J stated she wasn't sure but DO/LALD-A provided the document to the surveyor. She said DO/LALD-A had access to the letter because when DO/LALD-A requested the clearance letter BOM-J was busy so DO/LALD-A was instructed to retrieve it. BOM-J also explained that all LALD's had access to all employee records because often they fill in for	0 330			

Minnesota Department of Health

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0 330	Continued From page 5 other sites. During phone interview on March 7, 2025, at 12:30 p.m., the surveyor asked DO/LALD-A how a clearance letter for this facility was available when there was no evidence a background study was initiated for HFID 34601? DO/LALD-A stated, "I do not really know, I thought it looked weird but printed it out anyway." She also stated it was not in the PDF file format like it usually was. The surveyor asked if the clearance letter was edited to look original, DO/LALD-A stated, "no idea," and could not explain further. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	0 480			

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(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
0 480	Continued From page 6 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480			

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0 480	Continued From page 7 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660			

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0 660	Continued From page 8 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (life enrichment coordinator (LEC)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A and licensed assisted living director (LALD)-C stated upon hire, all staff filled out the history and symptom screen and completed the two-step skin TST on site. The Facility TB Risk Assessment for North campus completed on July 4, 2024, indicated the facility was at a low risk for TB transmission. LEC-G was hired May 13, 2024, to provide memory care residents with social activities and engagement at the licensee's sister facility under	0 660			

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0 660	Continued From page 9 health facility identification number (HFID) 32276. On March 3, 2025, LEC-G began working in the same role for the licensee's HFID 34601 (North campus). LEC-G's record included a Baseline TB Screening Tool for Health Care Workers file dated May 17, 2024, which include a TB history and symptom screen, and one negative TST completed on May 19, 2024. LEC-G's record lacked documentation of a required second TST. During observations on March 4, 2025, between 10:05 a.m. and 10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity to a few residents. On March 5, 2025, at 3:14 p.m., via email, DO/LALD-A stated the licensee's clinical team failed to implement a second TST per protocol. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated all health care workers would receive a baseline TB screening upon hire using a two-step TST or single blood test to test for TB, and the results would be maintained in the employee's medical record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 775	Continued From page 10	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions has the ability to affect all staff and 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, 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). Findings include: On facility tour with the director of operations/interim licensed assisted living director (DO/LALD)-A, licensed assisted living director (LALD)-C and maintenance technician (MT)-E on March 4, 2025, between 08:30 a.m. and 12:00 p.m., the following deficient conditions were observed: ELECTRICAL: The surveyor observed an open junction electrical box on the ceiling in the mechanical room and a white extension cord was plugged into a refrigerator in the nurse's office in the 10020	0 775			

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0 775	Continued From page 11 building. The surveyor observed a green extension cord plugged into a power strip in the office in the 10018 building. All open electrical boxes shall have a cover on them. Extension cords shall not be used for permanent use. KITCHEN HOOD PROTECTION SYSTEM: The surveyor observed the kitchen hood protection system had a non-compliant red tag on the system. Further review of the annual inspection report showed that the 12-year hydro test was due for the system in the 10020 building. The listed deficiency on the annual report shall be fixed. FIRE RATED DOORS/WALL: The surveyor observed a hole cut in the corridor wall and fan installed from a mechanical/IT room. Also, there were a few doors that had their closers removed. (kitchen/storage room) These were all in the 10020 building. The opening in the rated wall shall be closed or a code compliant fire damper installed. The closers shall be installed and these doors shall be kept closed at all times. LOCKS: The surveyor observed hasp style locks on the two back doors to the courtyard in the 10020 building.	0 775			

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0 775	Continued From page 12 These locks shall be removed. CARBON MONOXIDE PROTECTION: The surveyor observed no carbon monoxide protection in the 10018 building. Carbon monoxide protection shall be provided. The deficient conditions were visually verified by the DO/LALD-A, LALD-C and MT-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
01290 SS=G	144G.60 Subdivision 1 Background studies required (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. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01290			
			During the course of the survey, the		

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01290	Continued From page 13 licensee failed to ensure a background study was completed for one of two employees (life enrichment coordinator (LEC)-G). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated DO/LALD-A was aware of the required contents of employee records. LEC-G was hired May 13, 2024, to provide memory care residents with social activities and engagement at the licensee's sister facility under health facility identification number (HFID) 32276. On March 3, 2025, LEC-G began working in the same role for the licensee's HFID 34601. The licensee's Department of Human Services (DHS) NETStudy 2.0 Roster for HFID 34601 provided by licensee on March 3, 2025, indicated LEC-G lacked a completed background study. During observations on March 4, 2025, between 10:05 a.m.-10:45 a.m., the surveyor observed the licensee had two buildings, the North and South buildings. The North building had two secured units. LEC-G was sitting at the dining room table within the "Hope unit," providing a coloring activity	01290	licensee took action to mitigate the immediate risk. Non compliance remained and the scope and level remain unchanged.		

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01290	Continued From page 14 to a few residents. During interview at 10:40 a.m., LEC-G stated this was her second day at this location and LEC-G worked at the sister facility prior to this location. LEC-G's Final Registry Results Form dated January 7, 2025, indicated a background study was initiated for HFID 32276 (the licensee's sister facility), but required LEC-G to be fingerprinted for study completion. On March 5, 2025, at 3:01 p.m., via email, DO/LALD-A provided a background study notice under HFID 34601 dated January 14, 2025, indicating LEC-G was cleared. A NETStudy 2.0 screenshot dated March 6, 2025, at 8:07 a.m., indicated the only background study performed for LEC-G was for HFID 32276 on January 7, 2025. The screenshot also indicated LEC-G was listed as separated from HFID 32276 on January 22, 2025, and LEC-G was to be removed from direct patient care. The screenshot indicated LEC-G's NETStudy 2.0 profile lacked evidence of any additional background studies submitted for LEC-G under HFID 34601. During phone interview on March 6, 2025, at 8:45 a.m., LEC-G stated her work schedule was 9:00 a.m. to 5:00 p.m. and she began work at this facility on Monday, March 3, 2025. LEC-G stated her role included one on one activities with residents, coordinating large group activities, and helping observe/monitor changes in residents and reporting those changes to the nurse. LEC-G stated she was never instructed to get fingerprinted. On March 6, 2025, at 2:43 p.m., during phone interview, DO/LALD-A stated she had resubmitted	01290			

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01290	Continued From page 15 a background study on LEC-G to "cover their bases." The surveyor asked when LEC-G was background checked in January 2025, did LEC-G require fingerprinting? DO/LALD-A stated, "I don't think so." On March 6, 2025, at 6:19 p.m., Department of Human Services representative (DHSR)-N stated, via email, LEC-G did not have a background study clearance for 34601. DHSR-N stated LEC-G only had a background study submitted by HFID 32276 on January 7, 2025, but was never fingerprinted, so the background study was closed, and LEC-G was removed from the licensee's roster on January 22, 2025. DHSR-N further stated it appeared the clearance letter for LEC-G dated January 14, 2025, was originally issued to someone else and subsequently edited to insert LEC-G's name, address, a date, and the application number associated with the study from 32276 in place of a background study number. During phone interview on March 7, 2025, at 10:37 a.m., DO/LALD-A stated business office manager (BOM)-J completed background studies for all new hires. DO/LALD-A stated to ensure compliance, DO/LALD-A and BOM-J attempted to audit all employee records twice annually. On March 7, 2025, at 12:04 p.m., during phone interview, BOM-J explained the licensee was in the middle of going through software changes and had been busy dealing with that. BOM-J stated she used a checklist and set reminders to ensure tasks were completed. BOM-J was not sure if LEC-G completed fingerprinting and stated she did not have a reminder to follow up on that requirement.	01290			

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01290	Continued From page 16 The licensee's 4.02 Background Studies policy dated May 3, 2023, indicated the community will conduct a Minnesota DHS Background Study on all staff of community who will have independent, unsupervised contact with tenants or residents of community. No employee may have independent direct contact with any tenants or residents until acceptable result of the background study have been received. The community will not employ individuals whose results of the background study indicate disqualification for the position. The BOM would conduct quarterly audits to ensure all staff have cleared background studies. The NETStudy 2.0 System User Manual updated July 7, 2023, indicated on page 50: Fingerprint Deadline- study subjects who are required to be fingerprinted and photographed in most cases have 14 calendar days from the date the study is submitted to complete the process. NETStudy 2.0 users receive email notifications reminding them when a study subject is required to be fingerprinted but has not yet completed the process. Entities are responsible to ensure study subjects are fingerprinted by the deadline. If not, the background study application will close and the entity must submit a new application. The NETStudy 2.0 System User Manual also indicated on page 54: Supervision Status defined as Remove - the study subject must be removed from any position that requires a DHS background study. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

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01620	Continued From page 17 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, upon a change in condition (CIC) for one of one resident (R4). 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	01620			

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01620	Continued From page 18 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on March 3, 2025, at 10:30 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated assistant director of clinical services (ADCS)-D was the interim primary nurse as the former RN, RN-P's, last day was on January 3, 2025. ADCS-D worked on site one day a week and was on-call. DO/LALD-A stated RNs completed pre-admission assessment, face to face assessment upon admission, 14-day and 90-day assessments, and a CIC assessment such as a post hospitalization. R4 admitted on October 15, 2024, and had diagnoses of memory impairment, major cognitive disorder impaired gait mobility, and depression. R4's 14-day assessment completed by RN-P on October 24, 2024, indicated the following: -bed mobility: independent; -transfers: stand by assist due to unsteadiness; -ambulation: independent; -bed safety: standard bed type; -nutrition assistance: independent; and -evacuation acuity level: level 2-resident who is ambulatory requires moderate nursing care and requires moderate assistance with evacuation. R4's nurse note by licensed practical nurse (LPN)-O dated October 30, 2024, indicated R4 had an x-ray on his left foot due to tissue swelling and a request was sent to provider requesting to	01620			

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01620	Continued From page 19 reduce medications. Provider inquired about hospice (end of life care) as LPN-O indicated R4 required a wheelchair, total lift for transfers, and feeding assistance. R4's nurse note by LPN-O dated November 8, 2024, indicated R4 was admitted to hospice and a hospital bed, Hoyer lift (full body mechanical lift), and wheelchair were being delivered. Medication changes made and comfort pack medications would be delivered (medications that provide end of life comfort). R4's most recent 90-day assessment completed by RN-P dated January 2, 2025, was nearly identical to the 14-day assessment despite the documented observed changes made by LPN-O. The assessment included the same information: -bed mobility: independent; -transfers: stand by assist due to unsteadiness; -ambulation: independent; -bed safety: standard bed type; -nutrition assistance: independent; and -evacuation acuity level: level 2-resident who is ambulatory requires moderate nursing care and requires moderate assistance with evacuation. R4's Service Plan-Private Pay-MN signed February 3, 2025, indicated R4 required total assistance with dressing and grooming, repositioning, meals, daily inspection of Halo side rails by ULP, and assist of two staff using full body transfer using the Hoyer. The service plan was signed by LPN-O. R4's record lacked a change in condition assessment following a significant physical decline and admission to hospice service requiring multiple medication changes.	01620			

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NAME OF PROVIDER OR SUPPLIER PRELUDE HOMES AND SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 10018 RALEIGH ROAD WOODBURY, MN 55129		
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01620	Continued From page 20 During observation on March 4, 2025, at 12:42 p.m., R4 was sitting in a Broda chair (oversized padded wheelchair) in the dining room receiving feeding assistance by ULP-H. On March 4, 2025, at 1:02 p.m., ULP-H and ULP-I transferred R4 from the Broda chair to the bed using the Hoyer lift. Due to R4's height, both ULPs scooted R4 up into bed because his feet were touching the foot board of the bed. Both ULP's rolled R4 side to side to remove the body sling underneath and during that time R4 became resistive and yelled. During interview on March 4, 2024, at 2:39 p.m., LPN-O stated she managed medications, processed orders, communicated with providers and communicated with resident and their families. LPN-O stated ADCS-D had been the interim nurse and would come do assessments and helped with training. LPN-O explained R4 came in walking but now required two-person assist with Hoyer transfers. At the time of R4's admission, LPN-O stated she was on vacation, then in a week or two, he declined which the provider performed several different types of tests to find the cause of the decline but found nothing, so he was admitted to hospice care. During phone interview on March 5, 2025, at 1:13 p.m., ADCS-D stated she completed CIC assessments when there was a change in function such as transfers, meal assistance, or a deviation from the person's baseline. She also stated she would complete a CIC assessment upon admission to hospice care. ADCS-D stated when R4 was admitted to hospice, RN-P was working at the time so the assessment should have been completed by RN-P.	01620			

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01620	Continued From page 21 The licensee's 6.01 Assessments, Reviews & Monitoring policy last revised September 5, 2024, indicated ongoing reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for use of consumer side rails for two of two residents (R4, R2). 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	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
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02310	Continued From page 22 portion or all of the residents). The findings include: During facility tour on March 3, 2025, at 11:04 a.m., director of operations/interim licensed assisted living director (DO/LALD)-A stated both cottages (10018 and 10020) included memory care residents, and they tried not to have side rails but there were two families that insisted they have them. She said the licensee would obtain signed waivers and received provider orders to use side rails. Nursing related questions on side rail assessments were directed to interim assistant director of clinical services (ADCS)-D. R4 During observation on March 4, 2025, at 12:42 p.m., the surveyor observed R4's hi/low bed with two Halo side rails (round metal grab bar affixed to a hi/low bed) one on each side of the bed. The Halos were secured to the bed frame. On March 4, 2025, at 1:02 p.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-I transfer R4 into bed using full body transfer using mechanical lift (Hoyer). While turning side to side while in bed, R4 grabbed the Halo side rails to assist. R4 admitted on October 15, 2024, and had diagnoses of memory impairment, major cognitive disorder impaired gait mobility, and depression. R4's Service Plan-Private Pay-MN signed February 3, 2025, indicated R4 required total assistance with dressing and grooming, repositioning, meals, daily inspection of Halo side rails by ULP, and assist of two staff using full	02310			

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02310	Continued From page 23 body transfer using the Hoyer. R4's medical record included a provider order to utilize Halo side rails and risk vs benefit verbally signed by R4's designated representative on December 3, 2024, and December 4, 2024, respectively. R4's most recent quarterly nursing assessment dated January 2, 2025, indicated R4 utilized a standard bed and did not indicate he used side rails. R2 R2 admitted on January 27, 2025, and had diagnoses of dementia, chronic kidney disease, and diabetes. On March 4, 2025, at 10:45 a.m., during interview with R2's family member (FM)-L, the surveyor observed two Halo siderails on both sides of the bed. The Halo's were secured to the bed frame. R2's Service Plan-Private Pay-MN signed January 27, 2025, indicated R2 received assistance with bathing, dressing and grooming, mobility, hearing aids, and daily inspection of Halo side rails by ULP. R2's medical record included a risk vs benefit consent form signed on January 27, 2025. R2's 14-day nursing assessment dated February 10, 2025, indicated R2 utilized a halo device on the side of her bed. R4 and R2's medical record lacked: -an assessment of the resident's cognitive and physical status as they pertain to the side rail; -documentation of physical inspection of side rails	02310			

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02310	Continued From page 24 and mattress for areas of entrapment, stability, and correct installation; and -documentation of having checked the Consumer Product Safety Committee (CPSC) for any recalls. During interview on March 4, 2025, at 2:39 p.m., licensed practical nurse (LPN)-O stated if families insisted on having side rails, she obtained provider orders for side rails, ensured they were listed in the service plan, and physically checked the side rails and made sure the residents were capable of using them. LPN-O believed the side rails were assessed by the registered nurse but did not know how often they completed side rail assessments. During phone interview on March 5, 2025, at 11:15 a.m., ADCS-D explained she was not provided training by licensee on how to complete side rail assessments but utilized her previous experience by obtaining provider's orders, and discussed risk vs benefits of having a side rail. ADCS-D stated it was her process to ensure the side rails were installed properly and secured to the bed frame, make sure residents were using it properly. She was not aware of checking for recalls and did not have a manual available to reference. When R2 was admitted, ADCS-D stated she did not see the Halo on the bed but knew there was one based on interview with the resident and resident's designated representative. It was her practice to physically check the side rails and ensure proper use of them every 90 days. ADCS-D stated there was a new nurse starting that week so she was optimistic the new nurse would teach her all of the requirements. Regarding R4's most recent assessment, ADCS-D stated the former registered nurse (RN)-P was still working so she had no	02310			

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02310	Continued From page 25 involvement with R4's side rails. The Food and Drug Administration (FDA) Bed Rail Safety Activities document, dated February 27, 2023, included, "The FDA and Consumer Product Safety Commission (CPSC) have worked with manufacturers, health care practitioners, and consumer representatives to develop a voluntary consensus standard that applies to all adult portable adult bed rails, whether they are regulated by the FDA or the CPSC, to assure there are no gaps in federal oversight of the safety of these products. ASTM F3186-17: Standard Specification for Adult Portable Bed Rails and Related Products was published in 2017 and is recognized by the FDA. This standard establishes performance criteria for adult portable bed rails including resistance to entrapment." The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health's (MDH) Assisted Living: Resources and FAQ's website last updated on December 13, 2024, read under Consumer bed rails, that licensees should ensure, "an individual is an appropriate candidate for a bed rail, the licensee must assess the	02310			

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02310	Continued From page 26 individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, included "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's 6.28 Side rails policy revised December 3, 2024, indicated the licensee would assess the use, educate the resident or the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy also indicated the registered nurse would gather all pertinent data to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The policy lacked procedures for checking side rail recalls. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			

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Location:

Prelude Homes And Services
10018 Raleigh Road
Woodbury, MN55129
Washington County, 82

Establishment Info:

ID #: 0039225
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.

2-300 Personal Cleanliness

2-301.12A

**** Priority 1 ****

MN Rule 4626.0070A Food employees must clean their hands and exposed portions of their arms for 20 seconds, using soap in a handwashing sink that is properly equipped.

OBSERVED EMPLOYEE WASH HANDS FOR LESS THAN 10 SECONDS. REVIEWED PROPER HANDWASHING REQUIREMENTS WITH EMPLOYEE AND PERSON IN CHARGE.

Comply By: 03/04/25

4-500 Equipment Maintenance and Operation

4-501.114C1

**** Priority 1 ****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

MEASURED CHLORINE SANITIZER CONCENTRATION OF DISH MACHINES IN AUXILIARY SERVICE AREA (JOY AND VICTORY COTTAGE) AT 0PPM. ADVISED TO UTILIZE MAIN KITCHEN 3 COMPARTMENT SINK UNTIL UNITS ARE SANITIZING WITH A CL CONCENTRATION OF 50-100PPM.

Comply By: 03/18/25

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The

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date must not exceed the manufacturer's use-by-date.

OBSERVED PORTIONED BAGS OF BREAKFAST ITEMS (SAUSAGE LINKS, OMELETTES) IN THE COMMUNITY KITCHEN COOLERS AT 10020 WITH NO DATE LABELS. COMPLY WITH ABOVE RULE.

Comply By: 03/18/25

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.

OPERATOR STATED NO CHLORINE TEST KITS AVAILABLE BUT CHLORINE IN USE FOR DISH MACHINES IN ALL COMMUNITY KITCHENS. OBTAIN AND USE THESE STRIPS TO ENSURE EFFECTIVE SANITIZER CONCENTRATION. (50-100PPM).

Comply By: 03/18/25

2-300 Personal Cleanliness

2-302.11B

MN Rule 4626.0090B Food workers wearing fingernail polish or artificial fingernails must use intact single-use gloves while working with exposed food.

OBSERVED EMPLOYEE WITH POLISHED FINGERNAILS PORTION OUT APPLE SAUCE INTO INDIVIDUAL SERVING CUP. COMPLY WITH ABOVE RULE.

Comply By: 03/18/25

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED A CHIPPED BOWL AND DAMAGED CONTAINER LID IN FULL SERVICE KITCHEN (10020). ITEMS DISCARDED ON SITE.

Comply By: 03/04/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED SOME FOOD DEBRIS AND RESIDUE BUILD UP ON THE BOTTOM OF THE BOTTOM OF THE EVEREST AND HOSHIZAKI UNITS IN THE MAIN KITCHEN (10020). CLEAN AND MAINTAIN.

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6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND REMINDER POSTER AT HAND WASH SINK IN GRACE COTTAGE. SENT SAMPLE POSTER TO OPERATOR.

Comply By: 03/18/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED SOME RESIDUE BUILD UP UNDER THE PREP AND 3 COMPARTMENT SINK IN THE MAIN KITCHEN (10020). CLEAN AND MAINTAIN CLEAN.

Comply By: 03/18/25

Surface and Equipment Sanitizers

QUATERNARY AMMONIA: = 300PPM at Degrees Fahrenheit

Location: 3 COMP SINK DISPENSER 10020

Violation Issued: No

QUATERNARY AMMONIA: = 300PPM at Degrees Fahrenheit

Location: 3 COMP SINK DISPENSER 10018

Violation Issued: No

Chlorine: = 0PPM at Degrees Fahrenheit

Location: VICTORY COTTAGE DISH MACHINE

Violation Issued: Yes

Chlorine: = 0PPM at Degrees Fahrenheit

Location: GRACE COTTAGE DISH MACHINE

Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit

Location: JOY COTTAGE DISH MACHINE

Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit

Location: MERCY COTTAGE DISH MACHINE

Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit

Location: HOPE COTTAGE DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold(POTATO SALAD)

Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER

Violation Issued: No

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Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -5 Degrees Fahrenheit - Location: REACH IN FREEZER 1
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -5 Degrees Fahrenheit - Location: REACH IN FREEZER 2
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -7 Degrees Fahrenheit - Location: REACH IN FREEZER 3
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: EVEREST REACH IN
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -2 Degrees Fahrenheit - Location: HOSHIZAKI REACH IN
Violation Issued: No

Process/Item: Cold Hold/MARINARA
Temperature: 39 Degrees Fahrenheit - Location: KELVINATOR COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: VICTORY COTTAGE REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: JOY COTTAGE REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: GRACE COTTAGE REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: MERCY COTTAGE REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: HOPE COTTAGE REACH IN COOLER
Violation Issued: No

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Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	2	5

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ANNA BOHNEN. INSPECTION CONDUCTED IN PRESENCE OF JERMAINE RAYFORD, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD. THIS FACILITY CONSISTS OF TWO FULL SERVICE KITCHEN AREAS (10018, 10020) WITH TYPE I HOOD/ANSUL AND PREP SINK UTILIZED FOR LUNCH AND DINNER. BREAKFAST FOOD SERVICE IS PROVIDED BY FACILITY STAFF FROM FIVE COMMUNITY KITCHENS LOCATED THROUGHOUT THE FACILITY. THIS FACILITY DOES HAVE COMMERCIAL GRADE ANSI EQUIPMENT.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION
- HAND WASHING PROCEDURE
- GLOVE USE REQUIREMENTS
- NO BARE HAND CONTACT WITH RTE FOOD
- SANITIZER USE AND TEST KITS
- THERMOMETER USE/CALIBRATION
- DATE MARKING
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS
- PEST MANAGEMENT

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

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

I acknowledge receipt of the inspection report number 1036251037 of 03/04/25.

Certified Food Protection Manager KERI L. SPARISH

Certification Number: 46922 Expires: 06/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JERMAINE RAYFORD
PERSON IN CHARGE

Signed: _____

Jeff Johanson