Electronically Delivered

April 3, 2025

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

RE: Project Number(s) SL31433016

Dear Licensee:

On March 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 4, 2025, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

January 10, 2025

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

RE: Project Number(s) SL31433016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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 $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,

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31433	A. BUILDING: _____ B. WING _____	12/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL31433016-0 On December 2, 2024, through December 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility with Dementia Care license. An immediate order was identified on December 3, 2024, for SL 31433016-0, correction order 2310. The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, isolated.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 2, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living	0 460		

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0 460	Continued From page 2 director (LALD)-A and LALD-C stated the licensee did not use a system for the residents to summon for care assistance. LALD-C verbalized the licensee provided safety checks throughout the day and night of all residents. On December 3, 2024, at 9:15 a.m., house manager/unlicensed personnel (HM/ULP)-D stated residents did not have the means to request assistance with a call light, call pendant, or bell. HM/ULP-D stated the caregivers performed and documented resident safety check every two hours. On December 3, 2024, at 9:20 a.m., LALD-A stated she was not aware the licensee needed to provide a means for the residents to request assistance or the nurse to indicate in a residents nursing assessment why a system to summon staff would not be appropriate. In addition, LALD-A verbalized the licensee would implement a system for residents to summon assistance 24 hours a day, seven days a week. On December 3, 2024, at 10:00 a.m., during an interview, R2 stated he did not have a way to summon assistance from the caregiver, but they check on him often. The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated "1. The Housing Director will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		

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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 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	0 480		

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0 480	Continued From page 4 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 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 December 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with required content, failed to make the plan readily available, and failed to provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, from 10:30 a.m. to 12:30 p.m., during a facility tour with licensed assisted living director (LALD)-A and LALD-C, the surveyor observed the evacuation plans were not posted and resident room identifiers were not on unit doors. Fire evacuation diagrams were not posted around the facility or on any level. Individual rooms were not labeled but facility evacuation diagrams in the FESP were correct and labeled. Exit plan diagrams must be accurate and correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On December 4, 2024, at, 11:30 a.m., LALD-C provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 7 facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated August 2024, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 4, 2024, at 11:30 a.m., LALD-C	0 810		

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0 810	Continued From page 8 stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was a partially edited policy purchased from a third-party provider that was not specific to the facility. TRAINING The licensee failed to provide evacuation training to residents at least once per year. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On December 4, 2024, at 11:30 a.m., LALD-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. No other documentation was provided. On December 4, 2024, at 11:30 a.m., LALD-C stated they thought drills and training were being performed. A new employee has since been hired and has developed a plan for 2025 already. No additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 9 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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) completed supervision of unlicensed staff within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for two of two employees (house manager/unlicensed personnel (HM/ULP)-D, ULP-E). 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	01440		

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01440	Continued From page 10 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 2, 2024, at 12:51 p.m., the surveyor observed ULP-E assist R2 with medication administration. On December 3, 2024, at 8:13 a.m., the surveyor observed HM/ULP-D assist R2 with medication administration. HM/ULP-D and ULP-E were hired on February 6, 2023, and February 5, 2018, respectively, to provide direct care services to residents. HM/ULP-D and ULP-E's employee record lacked evidence a RN conducted direct supervision within 30 calendar days of performing delegated tasks from date of hire or first performed delegated tasks. On December 3, 2024, at 12:35 p.m., licensed assisted living director (LALD)-A stated the licensee did not complete a 30-day supervision of staff, by observation, within 30 days of performing delegated tasks by a RN. Also, LALD-A verbalized the licensee planned to get this completed by the registered nurse. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated September 26, 2024, included "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which	01440		

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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
01440	Continued From page 11 the individual begins working for Prelude Homes and Services and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. 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) completed an initial nursing assessment prior to signing the assisted living contract/providing services for one of one	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31433	A. BUILDING: _____ B. WING _____	12/04/2024

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

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01610	Continued From page 12 resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 December 2, 2024, at 12:51 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with medication administration. R2 was admitted on March 8, 2024, and had diagnoses including Parkinson's disease (a movement disorder of the nervous system) and dementia. R2's Service Plan, dated March 8, 2024, indicated R2 received services including assistance with meals, housekeeping, laundry, bathing, dressing, safety checks, and medication administration. R2's record included an Admission Assessment, dated March 17, 2024, nine days after R2's admission date, not prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moves in, whichever was earlier, as required. On December 3, 2024, at 10:42 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she did not realize R2's admission assessment was not completed timely.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31433	A. BUILDING: _____ B. WING _____	12/04/2024

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01610	Continued From page 13 On December 3, 2024, at 1:35 p.m., licensed assisted living director (LALD)-A stated R2 transferred from one of the licensee's other facilities to this facility on March 8, 2024, but R2's admission assessment was completed late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated September 5, 2024, indicated [Licensee] will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
02310 SS=G	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 including assessment and documentation of education of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 14 risk versus benefit of side rails for one of one resident (R2). This resulted in an immediate order on December 3, 2024. 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: R2 admitted on March 8, 2024, and had diagnoses which included Parkinson's disease and dementia. On December 3, 2024, at 10:33 a.m., the surveyor observed R2's bedroom with house manager/unlicensed personnel (HM/ULP)-D. Upon entry into R2's bedroom, the surveyor observed R2 sitting on the side of the hospital style bed with one left side rail in the upright position. The consumer style side rail was attached to the bed frame with a clamp but the side rail was not tightly secured and easily moved when touched. R2 stated "yes it is loose." HM/ULP-D stated the employees sometimes check the side rails and agreed R2's side rail was not secured tightly. R2's medical record included a Bed Safety Assessment and RN assessment, both dated November 13, 2024, which indicated R2 had "no assistive devices needed for bed." R2's medical record lacked:	02310		

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02310	Continued From page 15 -a side rail assistive device assessment; -manufacturer directions to maintain proper installation of the side rail; -documentation of having checked the Consumer Product Safety Committee (CPSC) for any recalls; and -documentation of discussion of the risks and benefits of side rails with the resident or resident's responsible party. On December 3, 2024, at 11:19 a.m., clinical nurse supervisor (CNS)-B stated she was not aware R2 had a side rail on his bed. Then, CNS-B verbalized it was a "Halo" and she was not aware a Halo device was considered a side rail. CNS-B stated she did not have the manufacturer directions for R2's side rail, did not check for recalls on the CPSC website, and had not completed an assessment which including the required information for R2's side rail. CNS-B further stated they had not discussed risk versus benefits with the resident. The MedaCure Universal QBar Assist Rails undated document included, "MedaCure's bed rails are designed and produced in accordance with the FDA's bed safety guidelines." 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	02310		

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02310	Continued From page 16 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 accessed on December 3, 2024, at 11:34 a.m., 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.	02310		

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02310	Continued From page 17 (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 Side rails policy dated September 26, 2024, included "When [Licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [Licensee] will assess the use, educate the resident, and when appropriate, 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. This policy shall be followed regardless of who owns or is supplying the side rail." Also, indicated "1. The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *12/03/24*
Time: 11:44:38
Report: 1036241286

Food and Beverage Establishment Inspection Report

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

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

License Categories:

Expires on: / /

Operator:

Phone #: 6515016516
ID #:

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

The following orders were issued during this inspection.

3-500C 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 date must not exceed the manufacturer's use-by-date.

OBSERVED AN OPENED BAG OF CHEESE AND OPEN CONTAINER OF COOL WHIP IN THE MAIN KITHCEN FRIDGE WITH NO DATE LABEL. COMPLY WITH ABOVE RULE.

Comply By: 12/04/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETER WAS AVAILABLE DURING INSPECTION. UPDATE 12/4/24: ESTABLISHMENT SENT MDH A PICTURE OF THERMOMETER THAT IS NOW ON SITE.

Comply By: 12/04/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE ON SITE FOR MEASURING THE UST OF THE DISH MACHINE. UPDATE 12/4/24: ESTABLISHMENT SENT MDH A PICTURE OF HOT DISK THERMOMETER THEY ACQUIRED FOR THE DISH MACHINE.

Comply By: 12/04/24

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.

NO TEST STRIPS ON SITE FOR MEASURING QUAT SANITIZER CONCENTRATION. PROVIDE AND MAINTAIN.

Comply By: 12/24/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED LEFTOVERS FOODS PREPARED THE PREVIOUS DAY (POT ROAST, STUFFING) AND BEING COLD HELD IN THE FRIDGE AND REHEATED AS NEED BE. DISCONTINUE SAVING AND SERVING LEFTOVERS.

Comply By: 12/04/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

OBSERVED SOME DAMAGE UNDER THE KITCHEN SINK AND EXPOSED WOOD. REPAIR AND MAINTAIN.

Comply By: 12/24/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 153 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 200 at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 10 Degrees Fahrenheit - Location: MAIN KITCHEN FREEZER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 38 Degrees Fahrenheit - Location: MAIN KITCHEN FRIDGE
Violation Issued: No

Type: Full
Date: *12/03/24*
Time: 11:44:38
Report: 1036241286
Prelude Homes & Services Llc

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: BASEMENT FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: BASEMENT FRIDGE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	4	2

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEDE HINNENDAEL. INSPECTION CONDUCTED IN PRESENCE OF MAKAYLA HANSON AND HEATHER ALLEN.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- SANITIZER USE AND TEST STRIPS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.

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

**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.

Type: Full
Date: *12/03/24*
Time: 11:44:38
Report: 1036241286
Prelude Homes & Services Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036241286 of 12/03/24.

Certified Food Protection Manager: HEATHER A. ALLEN

Certification Number: FM69962 Expires: 08/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
MAKAYLA HANSON
PERSON IN CHARGE

Signed: _____
Jeff Johanson