Electronically Delivered

April 28, 2025

Licensee
Prelude Homes & Services LLC
4650 White Bear Parkway
White Bear Lake, MN 55110

RE: Project Number(s) SL32276016

Dear Licensee:

On April 9, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 8, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

Electronically Delivered

February 19, 2025

Licensee
Prelude Homes & Services LLC
4650 White Bear Parkway
White Bear Lake, MN 55110

RE: Project Number(s) SL32276016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 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:

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
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 $3,500.00**. 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

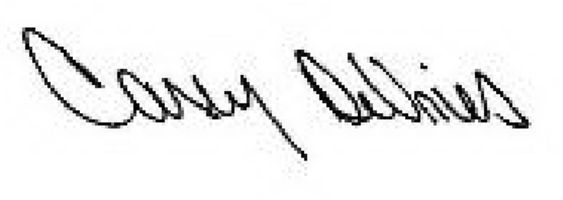
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	32276	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

(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: SL32276016-0 On January 6, 2024, through January 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on January 7, 2025, issued for SL32276016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 January 6, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving, hand hygiene, and catheter care for three of three employees (unlicensed personnel (ULP)-E, ULP-F, ULP-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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 510		

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0 510	Continued From page 4 ULP-E ULP-E was hired November 30, 2020, and began providing assisted living services August 1, 2021. On January 7, 2025, from 7:30 a.m., to 8:38 a.m., during continuous observation, the surveyor observed ULP-E prepare morning medications for R5. At 7:32 a.m., after completing preparation of morning medications, the surveyor observed ULP-E retrieve gloves and walk to the room of R5. After administering morning medications to R5, ULP-E put on gloves without completing hand hygiene and provided dressing assistance to R5. At 7:45 a.m., ULP-E assisted R5 into the bathroom. At 8:04 a.m., ULP-E removed their gloves, and assisted R5 to put on additional clothing, and without completing hand hygiene, at 8:14 a.m., assisted R5 to the main dining area. ULP-E completed hand hygiene at the kitchen sink at 8:19 a.m. ULP-E then put on clean gloves and began preparing food for R5. At 8:22 a.m., ULP-E removed their gloves, and without completing hand hygiene, began assisting with verifying the count of narcotic medications with another ULP. ULP-F ULP-F was hired on April 18, 2016, and began providing assisted living services August 1, 2021. On January 7, 2025, from 8:44 a.m., to 9:04 a.m., during continuous observation, the surveyor observed ULP-F assist R6 with morning cares in conjunction with ULP-G. At 8:44 a.m., the surveyor observed ULP-F retrieve and put on gloves without completing hand hygiene. The surveyor observed ULP-F remove soiled clothing from R6, and without changing gloves or completing hand hygiene, ULP-F provided	0 510		

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0 510	Continued From page 5 perineal cares and applied barrier cream to R6's perineum. At 8:53 a.m., after applying barrier cream to R6, ULP-F removed the soiled gloves, and without completing hand hygiene put on a new clean pair of gloves. At 8:57 a.m., ULP-F and ULP-G assisted R6 out of bed using a Hoyer lift. At 8:58 a.m., ULP-F removed gloves and without completing hand hygiene put on new gloves and assisted R6 with oral cares. At 9:01 a.m., ULP-F removed gloves and without completing hand hygiene, escorted R6 out of their room and to the dining area for breakfast. On January 7, 2025, at 9:04 a.m., ULP-F stated they had worked with the licensee for nine years and were trained by the nurse. ULP-F stated infection control and hand washing was included in orientation and annual training modules provided by the licensee. ULP-G ULP-G was hired October 28, 2024, to provide assisted living services. On January 7, 2025, from 8:44 a.m., to 9:04 a.m., during continuous observation, the surveyor observed ULP-G assist R6 with morning cares in conjunction with ULP-F. At 8:44 a.m., the surveyor observed ULP-G retrieve and put on gloves without completing hand hygiene. At 8:57 a.m., ULP-F and ULP-G assisted R6 out of bed using a Hoyer lift. At 9:01 a.m., the surveyor observed ULP-G gather trash bags and exit the room wearing the same gloves they entered the room wearing. ULP-G disposed of the trash bags in a room on the opposite side of the unit. On January 8, 2025, at 10:32 a.m., clinical nurse supervisor (CNS)-C stated staff should be changing gloves between cares and hands	0 510		

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0 510	Continued From page 6 should be cleansed before, after, and in between glove changes. CNS-C stated that they may encourage staff to carry hand sanitizer on their person to assist with ensuring hands are being cleaned. The licensee's 8.01 Infection Control Policy dated March 9, 2023, indicated the licensee's infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a indicated: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 660	Continued From page 7	0 660		
0 660 SS=F	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 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for three of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-E, ULP-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 is issued at a widespread scope (when problems	0 660		

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0 660	Continued From page 8 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated July 4, 2024, indicated the facility had a low risk. CNS-C CNS-C was hired November 6, 2023, to provide assisted living services. CNS-C's record contained one of the two required steps of the TB test with an administration date of November 6, 2023, and a reading date of November 9, 2023. CNS-C's employee record lacked any additional documentation indicating completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-E ULP-E was hired November 30, 2020, and began providing assisted living services on August 1, 2021. ULP-E's record contained one of the two required steps of the TB test with an administration date of December 13, 2023, and reading date of December 15, 2023. ULP-E's employee record lacked any additional documentation indicating completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-G ULP-G was hired on October 28, 2024, to provide assisted living services. ULP-G's employee record lacked documentation	0 660		

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0 660	Continued From page 9 indicating completion of a two-step TST or other evidence of TB screening such as a blood test. On January 8, 2025, CNS-C stated it was the practice of the licensee to only complete one of the two required steps of the TB test. Additionally, CNS-C stated that during all new staff orientation, only a single step was completed; all records reviewed would likely show only a single step TB test. The licensee's 8.01 Infection Control policy dated March 9, 2023, indicated the licensee's infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The CDC's Morbidity and Mortality Weekly Report, Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, dated December 30, 2005, indicated that all HCW's (health care workers) should receive baseline TB screening upon hire, using two-step TST or a single BAMT (Blood Assay for Mycobacterium tuberculosis) to test for infection with M. tuberculosis. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the	0 660		

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0 660	Continued From page 10 employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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	32276	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

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0 680	Continued From page 11 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 6, 2025, at 11:15 a.m., the surveyor retrieved the licensee's EPP from licensed assisted living director (LALD)-A. LALD-A stated the binder was complete in its required contents and was normally stored within the unlocked nursing office. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - policies and procedures for subsistence needs for staff and residents; - policies and procedures for food, water, medical supplies and pharmaceutical supplies; - policies and procedures for the safe/sanitary storage of provisions;	0 680		

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0 680	Continued From page 12 - roles under wavier declared by secretary; - policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver. On January 8, 2025, at 11:31 a.m., LALD-A stated the development of the licesnee's EPP was the responsibility of the LALD, environmental services, the director of training and development, and the director of culinary. LALD-A stated that some of the requirements were just recently developed, but had not yet been added to the EPP. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would develop an emergency preparedness plan with all required content of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	0 780		

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0 780	Continued From page 13 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide reliable and unobstructed egress from the facility to the public way. This deficient condition had 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). The findings include: On January 7, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, licensed assisted living director (LALD)-B, and maintenance (M)-H.	0 780		

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0 780	Continued From page 14 The surveyor found that the gate from the patio leading to the public way was locked with a cable style bicycle lock. The gate could not be operated without entering the correct letter combination. Egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. The doors from all the locked dementia wings leading to the fenced courtyard were equipped with drop pin patio door style locks installed at 78 inches from the finished floor. LALD-A said that all the doors leading to the patio are equipped with those style of locks. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches (864 mm) minimum and 48 inches (1219 mm) maximum above the finished floor. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 15 by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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 January 7, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, licensed assisted living director (LALD)-B, and maintenance (M)-H. The following was observed. Resident room 202 was missing the baseboard trim throughout the room. LALD-A stated that the resident had removed it. Trim shall be maintained as provided and approved at time of construction. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 16 (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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had	0 810		

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0 810	Continued From page 17 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 January 7, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: 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.	0 810		

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0 810	Continued From page 18 DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on March 1, 2024, December 18, 2024, December 23, 2024, a.m. shift, and December 23, 2024, p.m. shift. In an email on January 7, 2025, LALD-A provided a proposed fire drill schedule for 2025 that appears to meet the statutory requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents.	0 910		

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0 910	Continued From page 19 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On January 6, 2025, at 1:28 p.m., licensed assisted living director (LALD)-A provided a blank copy by email, of the licensee's contract used by all residents. The blank copy of the contact contained the name, address, telephone number, and a section titled "License #" followed by a blank space for the license number of the facility to be entered. The licensee's Resident Contract for Assisted Living lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On January 7, 2025, at 12:48 p.m., LALD-A stated the blank section was used to enter the licensee's license number. LALD-A stated it was something that they were told about in prior surveys and were instructed to use their license number, and they thought that they should be using their HFID, as that stays the same, but their license number changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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01290	Continued From page 20	01290		
01290 SS=I	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 licensee failed to ensure a background study was completed and a clearance received prior to staff providing services for one of two employees (unlicensed personnel (ULP)-G) and failed to affiliate a background study with the licensee's health facility identification for one of two employees (ULP-E). 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	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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01290	Continued From page 21 portion or all of the residents). The findings include: ULP-G ULP-G was hired October 28, 2024, to provide assisted living services. ULP-G's employee record lacked evidence to indicate the licensee had submitted a background study with NETStudy 2.0 (a web-based system used to submit background study requests to the Department of Human Services) under the current assisted living license and affiliated to the licensee's health facility identification (HFID) number prior to the start of the survey. The licensee's weekly schedule dated January 5, 2025, through January 11, 2025, indicated that ULP-G had worked in an unsupervised capacity from 7:00 a.m., to 3:00 p.m., on January 5, 2025, January 6, 2025, and January 7, 2025. ULP-E ULP-E was hired November 30, 2020, and began providing assisted living services August 1, 2021. ULP-E's employee record contained a NETStudy 2.0 background study clearance for an affiliated, but closed license with HFID #27917. ULP-E's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license and affiliated to the licensee's HFID prior to the start of the survey. The licensee's weekly schedule dated January 5, 2025, through January 11, 2025, indicated that ULP-E had worked in an unsupervised capacity from 7:00 a.m., to 3:00 p.m., on January 5, 2025,	01290		

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01290	Continued From page 22 and January 7, 2025. On January 7, 2025, from 7:27 a.m., to 8:38 a.m., the surveyor observed ULP-E administer medications and provide assistance with activities of daily living (ADL) to residents residing within the facility without direct supervision. On January 7, 2025, at 2:28 p.m., licensed assisted living director (LALD)-A stated the business manager had "dropped the ball" and had not run background checks for the licensee as required. LALD-A stated they would begin working on verifying all other staff had affiliated background study clearances. The licensee's 4.02 Background Studies policy dated May 3, 2023, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. Additionally, no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The Licensee's 4.05 Employee Records policy dated May 3, 2023, indicated that employee records will include documentation of a competed criminal background study. Additionally, the policy indicated that employee Record audits will take place every quarter - led by the Business Office Manager. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01620	Continued From page 23	01620		
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 interview and record review, the licensee failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (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	01620		

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01620	Continued From page 24 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: R2 was admitted to the licensee and began receiving assisted living services on May 4, 2024. R2's diagnoses included dementia, osteoarthritis, peripheral vascular disease, vitamin D deficiency, diabetic neuropathy, insomnia, anemia, cerebrovascular disease, diabetic foot ulcer, chronic obstructive pulmonary disease, diabetes mellitus with hyperglycemia, right foot amputation, weight loss of unknown etiology, autism spectrum, hemiparesis, cachexia, depression, and A-Fib. R2's Service Plan - Modification dated July 5, 2024, indicated R2 received assistance with activities, bathing, linen changes, behavior management, dressing, grooming, housekeeping, laundry, medications, nail care, oral cares, vital signs, safety checks, toileting, and transfers. R2's record contained 90-day assessments dated September 18, 2024, and December 17, 2024, which indicated that 91 days had passed between assessment dates. On October 23, 2024, clinical nurse supervisor (CNS)-A stated they had miscalculated the dates between assessments. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated September 5, 2024, the resident reassessment and monitoring must be	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

(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
01620	Continued From page 25 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents residing within the licensee's memory care unit. 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	01/08/2025

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PRELUDE HOMES & SERVICES LLC	4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110

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01880	Continued From page 26 portion or all of the residents). The findings include: On January 6, 2025, at 11:05 a.m., during a tour of the facility, the surveyor observed a medication cabinet that appeared to be slightly ajar in one of the licensee's three secured memory care units. The cabinet door was locked upon initial inspection but was able to be opened when applying light pressure to the right lower corner of the cabinet door. The surveyor observed the contents of the medication cabinet would have been easily accessible to unauthorized individuals. Licensed assisted living director (LALD)-A, who was in attendance during the tour, attempted to secure the medication cabinet but was unable to do so. LALD-A assigned a staff to monitor the medication cabinet and called maintenance to repair the lock. On January 8, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-C stated the medication cabinets should be always secured. CNS-C stated they try to monitor cabinets to ensure they are secured, and staff are expected to notify them in the event of the cabinets needing to be repaired. The licensee's 7.11 Medication Storage policy, dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	01/08/2025

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01880	Continued From page 27 days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information and failed to ensure time sensitive medications were labeled with the date opened. This had the potential to affect all 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 the potential to affect a large portion or all of the residents). The findings include: On January 8, 2025, at 10:48 a.m., during an audit of the licensee's medication cabinet in the licensee's unit titled Peace Cottage, the surveyor observed an insulin pen of Lantus 100units/mL, belonging to R2 which lacked an opened-on date.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	01/08/2025

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01890	Continued From page 28 On January 8, 2025, at 11:11 a.m., during an audit of the licensee's medication cabinet in the licensee's unit titled King's Cottage, the surveyor observed an unidentified white oval pill in the back corner the licensee's medication cabinet. ULP-I stated they were trained to package up loose medications and then notify nursing staff. On January 8, 2025, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated insulin pens should be labeled upon opening, and that staff are trained to contact the nurse when a loose pill is found. The licensee's 7.11 Medication Storage policy indicated when medications are managed and stored by Prelude Homes and Services, medications will be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *01/06/25*
Time: 15:12:45
Report: 8058251001

Food and Beverage Establishment Inspection Report

Location:

Prelude Homes and Services
4650 White Bear Parkway
White Bear Lake, MN55110
Ramsey County, 62

Establishment Info:

ID #: 0038184
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516533288
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: KING-DISH MACHINE
Violation Issued: No

Chlorine: = 50 PP at Degrees Fahrenheit
Location: PEACE-DISH MACHINE
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: COMPASSION-DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: RICE
Temperature: 160 Degrees Fahrenheit - Location: COOKED
Violation Issued: No

Process/Item: CHICKEN
Temperature: 33 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 34 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 15:12:45
Report: 8058251001
Prelude Homes and Services

Food and Beverage Establishment Inspection Report

Process/Item: HAM
Temperature: 41 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: EGG
Temperature: 41 Degrees Fahrenheit - Location: KING COOLER
Violation Issued: No

Process/Item: PANCAKE
Temperature: 40 Degrees Fahrenheit - Location: PEACE COOLER
Violation Issued: No

Process/Item: SAUSAGE
Temperature: 41 Degrees Fahrenheit - Location: COMPASSION COOLER
Violation Issued: No

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

HRD INSPECTOR ZACH MORTH

DISCUSSED NOROVIRUS PREVENTION, EMPLOYEE EXCLUSION, FOOD STAFF OVERSIGHT OF DROP KITCHEN IN EACH OF THE THREE WINGS ADJACENT TO THE SERVING KITCHEN

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058251001 of 01/06/25.

Certified Food Protection Manager: VANESSA SORENSON

Certification Number: 116315 Expires: 04/06/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

VANESSA SORENSON
KITCHEN MANAGER

Signed: _____

Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us