



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

Electronically Delivered

August 10, 2023

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

RE: Project Number(s) SL32276015

Dear Licensee:

On August 2, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 17, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 17, 2023 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on February 17, 2023, found not corrected at the time of the August 2, 2023, follow-up survey and/or subject to penalty assessment are as follows:

**1950-Administration Of Treatments And Therapy-144g.72 Subd. 4**

The details of the violations noted at the time of this follow-up survey completed on August 2, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

**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.

**IMPOSITION OF FINES:**

- 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.

**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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Hill". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke at the end.

Jonathan Hill, Supervisor  
State Evaluation Team  
Email: [jonathan.hill@state.mn.us](mailto:jonathan.hill@state.mn.us)  
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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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
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{0 000}	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been 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.</p> <p>INITIAL COMMENTS: Project SL32276015-2</p> <p>On July 31, 2023 through August 2, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a licensing order follow-up survey completed on May 4, 2023. At the time of the survey, there were 29 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following order was reissued:</p> <p>1950 - Administration of treatments and therapy</p>	{0 000}	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
{0 480} SS=F	<p><b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b></p> <p>(13) offer to provide or make available at least the</p>	{0 480}		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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{0 480}	Continued From page 1  following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and  This MN Requirement is not met as evidenced by: No Further Action Needed	{0 480}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment  (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;  (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and  This MN Requirement is not met as evidenced by: No Further Action Needed	{0 790}		
{0 800} SS=F	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	{0 800}		

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{0 800}	Continued From page 2  repair program.  This MN Requirement is not met as evidenced by: No Further Action Needed	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	{0 810}		

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{0 810}	Continued From page 3  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: No Further Action Needed	{0 810}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy  Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and  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) provided training and verified competency of unlicensed personnel (ULPs) to perform a delegated treatment or	{01950}		

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{01950}	<p>Continued From page 4</p> <p>therapy for one of one resident (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5's diagnoses included Alzheimer's dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's service plan, dated December 29, 2022, indicated R5 received services including assistance with bathing, activities of daily living, toileting, transfers, housekeeping, laundry, and meals.</p> <p>R5's RN assessment, dated May 16, 2023, indicated R5's recommended diet was, "Regular, Regular- Nectar Thick," and indicated "Complies with diet -specify: Nectar thick liquids". The assessment further indicated, under the treatment or therapy section, "no treatments required".</p> <p>R5's physician's order signed January 23, 2023, indicated, "Recommended Diet: Nectar Liquids -Mechanical altered (minced and moist) Nectar thick (mildly thick)".</p> <p>R5's Individualized Treatment and Therapy Plan, printed July 31, 2023, indicated staff assisted R5 with meals and liquids to be "Nectar/mildly thick"</p>	{01950}		
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{01950}	<p>Continued From page 5</p> <p>three times daily.</p> <p>ULP-B was hired April 25, 2022, and provided direct care services to residents.</p> <p>ULP-F was hired April 18, 2016, and began providing direct assisted living services August 1, 2021.</p> <p>ULP-J was hired November 4, 2019, and began providing direct assisted living services August 1, 2021.</p> <p>R5's Service Recap Summary for July 1-30, 2023, indicated ULP-B assisted R5 with escort to meals and nectar thickened liquid on July 1, 23, 27, and 28, 2023.</p> <p>R5's Service Recap Summary for July 1-30, 2023, indicated ULP-F assisted R5 with escort to meals and nectar thickened liquid on July 2, 4, 5, 7, 11-13, 15, 16, 26, 26, 29, and 30.</p> <p>R5's Service Recap Summary for July 1-30, 2023, indicated ULP-J assisted R5 with escort to meals and nectar thickened liquid on July 2, 12, 16, 20, 21, 28, and 30.</p> <p>ULP-B, ULP-F, and ULP-J's records lacked documentation the RN trained and evaluated their competency to perform the delegated task of administering thickened liquids to R5, including: -instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures.</p> <p>On August 2, 2023, at 9:42 a.m., director of nursing (DON)-D stated ULP training was present on R5's service plan. DON-D further stated they</p>	{01950}		
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{01950}	<p>Continued From page 6</p> <p>added training on administering thickened liquids to the new employee training for new employees. DON-D stated she had not documented training or competency to any existing staff regarding administering thickened liquids for R5.</p> <p>The licensee's correction order documentation in response to the order issued after the follow-up licensing survey ending May 4, 2023, indicated, "Director of Clinical services added diet and liquid modifications to the competency packet. New staff are training on this during orientation, current staff are being trained". The documentation lacked a date for the identified actions.</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy, revised April 21, 2023, indicated, "Staff who provide delegated nursing or therapy tasks to residents at [licensee] will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks.</p> <p>No further information provided.</p>	{01950}		
{02040} SS=F	<p><b>144G.81 Subdivision 1 Fire protection and physical environment</b></p> <p>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to</p>	{02040}		

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{02040}	<p>Continued From page 7</p> <p>protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.</p> <p>This MN Requirement is not met as evidenced by: No Further Action Needed</p>	{02040}		



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

Electronically Delivered

May 17, 2023

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

RE: Project Number(s) SL32276015

Dear Licensee:

On May 4, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 17, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 17, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on February 17, 2023, found not corrected at the time of the May 4, 2023, follow-up survey and/or subject to penalty assessment are as follows:

**1290-Background Studies Required-144g.60 Subdivision 1- \$3,000.00**  
**1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3**  
**1950-Administration Of Treatments And Therapy-144g.72 Subd. 4**

The details of the violations noted at the time of this follow-up survey completed on May 4, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 4, 2023, we identified the following violation(s):

**0250-Conditions-144g.20 Subdivision 1**

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

## **IMPOSITION OF FINES:**

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.

## **CORRECTION ORDER RECONSIDERATION PROCESS**

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Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

## **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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue

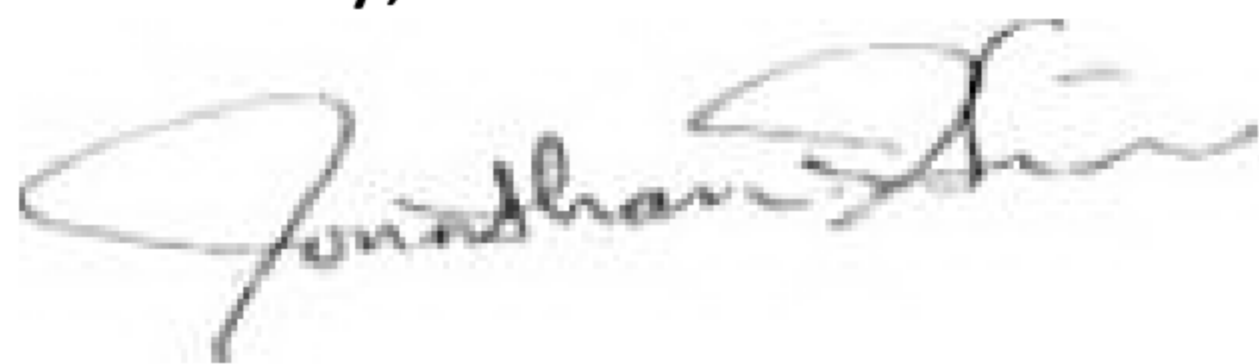
contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

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

Sincerely,



Jonathan Hill, Supervisor  
State Evaluation Team  
Email: jonathan.hill@state.mn.us  
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

Minnesota Department of Health

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{0 000}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders have been issued pursuant to a survey.</p> <p>Determination of whether a violation has been 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.</p> <p>INITIAL COMMENTS: Project SL32276015-1</p> <p>On May 1, through May 4, 2023, the Minnesota Department of Health conducted a desk audit with the above provider to follow-up on orders issued pursuant to a survey completed on February 17, 2023. At the time of the survey, there were 26 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.</p> <p>0250 new order issued; 1290 reissued as identified below: On May 2, 2023, at 6:25 p.m., an immediate correction order was issued for licensing order 1290. As of May 3, 2023, at 11:52 a.m., the immediacy of licensing order 1290 was removed, however the scope and level remained unchanged. 1940, 1950 were reissued.</p>	{0 000}	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250 SS=F	<p><b>144G.20 Subdivision 1 Conditions</b></p> <p>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:</p> <p>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;</p> <p>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;</p> <p>(3) performs any act detrimental to the health, safety, and welfare of a resident;</p> <p>(4) obtains the license by fraud or misrepresentation;</p> <p>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;</p> <p>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;</p> <p>(7) interferes with or impedes a representative of the department in contacting the facility's residents;</p> <p>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;</p> <p>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;</p> <p>(10) destroys or makes unavailable any records</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 2</p> <p>or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).</p> <p>The findings include:</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 3</p> <p>The licensee had an assisted living with dementia care license issued January 1, 2023, with an expiration date of December 31, 2023.</p> <p>A routine Assisted Living Facility with Dementia Care (ALFDC) survey was completed February 17, 2023. The survey identified deficiencies including the following: -tag identification number (ID) 1290, statute 144G.60 Subd. 1, Background Studies Required</p> <p>The above correction order was issued at a scope and severity level of "C", indicating, "This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents)." The deficiency was issued March 22, 2023, and directed to be corrected within two days of receipt.</p> <p>The licensee's documentation of actions taken to comply with correction order tag ID 1290 included the following:</p> <p>- Plan of Correction: "Have contacted [Minnesota Department of Health] MDH for their assistance on ensuring that all employees (both those who already have a current background study and new hires) have a background study completed and documented per address that they provide/expected to provide services at."</p> <p>- Completion Date: "4/5/2023" (12 days after the deficiency was required to be corrected), "all staff affiliated to correct [health facility identification] HFID, [LALD-G] contacted [supervisor (S)-O]</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 4</p> <p>from MDH to inform her that this was finished, old comp home care license HFID to be closed".</p> <p>- Plan for continued monitoring: "[LALD-G] will work with [office manager (OM)-P] to ensure that backgroudnm [sic] studies are being completed correctly moving forward".</p> <p>On May 2, 2023, at 6:25 p.m., during a licensing order follow-up survey, an immediate correction order was identified related to tag ID 1290, and issued at scope and severity level "I", indicating, "This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents)." The immediate order was issued due to an incomplete background study indicating supervision was required for an employee hired February 20, 2023, despite the licensee's indication the deficient practice was corrected April 5, 2023 (See correction order tag ID 1290).</p> <p>In addition to tag ID 1290, the survey completed February 17, 2023, identified the following deficiencies: -tag ID 1940, statute 144G.72 Subd. 3, Individualized Treatment or Therapy Management Plan; and -tag ID 1950, statute 144G.72 Subd. 3, Administration of Treatments and Therapy.</p> <p>Both correction orders listed above were issued at a scope and severity level of "D", indicating, "This practice resulted in a level two violation (a</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 5</p> <p>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 deficiencies were issued March 22, 2023, and directed to be corrected within seven days of receipt.</p> <p><b>1940 INDIVIDUALIZED TREATMENT OR THERAPY MANAGEMENT PLAN</b> The licensee's documentation of actions taken to comply with correction order tag ID 1940 included the following:</p> <ul style="list-style-type: none"> <li>- Plan of Correction: "Immediately corrected. All assessments now conducted by RN";</li> <li>- Completion date: "3/28/23"; and</li> <li>- Plan for continued monitoring: "Director of Clinical Services will ensure that all service plans and residents care plan accurately reflects all treatments and services delivered to residents. This will be done during admission assessment, 14 and 90 day assessment and upon initiation of new treatment and therapy services".</li> </ul> <p>The correction documentation lacked actions to address deficiencies related to development of an individualized treatment or therapy management plan, as identified in the original correction order. This indicated the licensee did not understand the nature of the deficiencies and related statutory requirements.</p> <p>On May 1, 2023 at 11:33 a.m., through May 4, 2023, at 12:18 p.m., during a licensing order follow-up survey, continued noncompliance was</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 6</p> <p>identified related to tag ID 1940, and the originally identified resident record, despite the licensee's indication the deficient practice was corrected March 28, 2023. (See correction order tag ID 1940.)</p> <p><b>1950 ADMINISTRATION OR TREATMENTS AND THERAPIES</b></p> <p>The licensee's documentation of actions taken to comply with correction order tag ID 1950 included the following:</p> <ul style="list-style-type: none"> <li>- Plan of Correction: "Waiting for pricing on pre-thickened fluids";</li> <li>- Completion date: "3/28/23"; and</li> <li>- Plan for continued monitoring: "Director of clinical services will review [sic] ensure a review of residents service plan and ensure that all services are on caregivers task list".</li> </ul> <p>The correction documentation lacked actions to address deficiencies related to training and instruction for unlicensed personnel (ULP) performing the delegated task, as identified in the original correction order. This indicated the licensee did not understand the nature of the deficiencies and related statutory requirements.</p> <p>On May 1, 2023 at 11:33 a.m., through May 4, 2023, at 12:18 p.m., during a licensing order follow-up survey, continued noncompliance was identified related to tag identification number 1950, and no training documented, despite the licensee's indication the deficient practice was corrected March 28, 2023. (See correction order tag ID 1950.)</p> <p>The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five of the application), indicated, "I certify I have read and</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 7</p> <p>understand the following:" A check mark was placed before each of the following:</p> <ul style="list-style-type: none"> <li>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.</li> <li>- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.</li> <li>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.</li> <li>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.</li> <li>- Reporting of Maltreatment of Vulnerable Adults.</li> <li>- Electronic Monitoring in Certain Facilities.</li> <li>- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the</li> </ul>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 8</p> <p>appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.</p> <p>- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.</p> <p>- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.</p> <p>- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.</p> <p>- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure</p>	0 250		

Minnesota Department of Health

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0 250	<p>Continued From page 9</p> <p>and to keep them current as applicable.</p> <p>Application for Assisted Living Licensure, page 6, was electronically signed by licensed assisted living director (LALD)-C December 21, 2022.</p> <p>The licensee did not implement the following policies and procedures: -conducting and handling background studies on employees; -medication and treatment management; and -delegation of tasks by registered nurses or licensed health professionals.</p> <p>On May 2, 2023, at approximately 2:30 p.m., director of nursing/director of clinical services (DON)-D stated many of the corrections were still in process, but that she retrained staff and verified competency for delegated tasks. DON-D further stated she thought most staff orientation was completed through online training, but was not sure, because LALD-C and LALD-G handled the orientation. DON-D further stated she did not know how long ULPs participated in training/shadowing another ULP, and administrative staff handled that process. DON-D stated she was not involved with and did not know the statutes related to background studies. DON-D stated she only started in August 2022, so was "still learning all the rules."</p> <p>On May 4, 2023, at 10:21 a.m., LALD-C stated the licensee had gone through a lot of staffing changes and that the office manager (OM)-P was still new, and learning the processes, especially regarding background studies. LALD-C further stated she had not been in the role for very long and was working to learn all the new statutes, and make corrections to identified deficiencies while responding to investigations, running the facility,</p>	0 250		

Minnesota Department of Health

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0 250	Continued From page 10 and also training new staff.  As a result of this licensing order follow-up survey, the following orders were re-issued: 0250, 1290 (at level I-immediate), 1940, and 1950, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
{0 480} SS=F	<b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b>  (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and  This MN Requirement is not met as evidenced by: No further action needed	{0 480}		
{0 790} SS=F	<b>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</b>  (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;  (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	{0 790}		

Minnesota Department of Health

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{0 790}	Continued From page 11  fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and  This MN Requirement is not met as evidenced by: No further action needed	{0 790}		
{0 800} SS=F	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 by: No further action needed	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	{0 810}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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{0 810}	<p>Continued From page 12</p> <p>evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: No further action needed</p>	{0 810}		
{01290} SS=1	<p>144G.60 Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be</p>	{01290}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01290}	<p>Continued From page 13</p> <p>classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to complete a background study (BGS) prior to staff providing direct care services, for one of four employees, unlicensed personnel (ULP)-K. This had potential to affect all 26 residents in the facility. This resulted in the issuance of an immediate correction order on May 2, 2023, at 6:25 p.m.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-K's employee record lacked evidence of current, cleared BGS prior to providing direct care services. ULP-K's record included a hire date of February 20, 2023 (four days after the previous survey exit February 17, 2023).</p> <p>The licensee's employee work log for February 15 through May 1, 2023, indicated ULP-K was scheduled to work the following days:</p>	{01290}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01290}	<p>Continued From page 14</p> <p>-March 9, 10, 15, 19, 30, and 31; and -April 1, 7, 8, 12, 13, 15, 23, and 26-29.</p> <p>R6 had diagnoses including Parkinson's dementia, anxiety, and high blood pressure. R6's medication administration record (MAR) for April 1-30, 2023, indicated ULP-K administered medications to R6 at the following times: -April 12, 2023, at 3:38 p.m., and 6:58 p.m.; -April 13, 2023, at 3:27 p.m., and 7:04 p.m.; -April 15, 2023, at 7:16 p.m.; -April 26, 2023, at 3:21 p.m., 3:23 p.m., and 7:45 p.m.; -April 27, 2023, at 3:21 p.m., and 7:26 p.m.; -April 28, 2023, at 3:14 p.m., 3:16 p.m., 7:16 p.m., and 7:17 p.m.; and -April 29, 2023, at 3:15 p.m., 3:19 p.m., 7:13 p.m., and 7:14 p.m.</p> <p>R6's Services Delivered record from April 1 to May 1, 2023, indicated ULP-K provided direct cares for R6, including assistance with toileting, activities of daily living (ADLs), vital signs, meals, laundry, and performing safety checks on: April 1, 12, 13, 14, 15, 26, and 26-30, 2023. R6's service plan dated May 1, 2023, indicated R6 received services including assistance with monitoring vital signs, medication administration, bathing, ADLs, meals, laundry, and housekeeping.</p> <p>ULP-K's record included a Final Registry Results Form from the Minnesota Department of Human Services (DHS), dated May 1, 2023. The form indicated, "This applicant has not been previously determined eligible for employment and must be fingerprinted."</p> <p>On May 2, 2023, at 11:58 a.m., LALD-G stated via email, the facility was, "having an issue with locating [ULP-K's] background clearance.</p>	{01290}		

Minnesota Department of Health

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{01290}	<p>Continued From page 15</p> <p>[ULP-K] completed the process and was finger printed in February. Our Business Office Manager has a call out to DHS to try and see why [ULP-K] is not showing up on the roster." LALD-G further stated, "...DHS is closed today and we have still yet to receive a response."</p> <p>On May 2, 2023, at 12:55 p.m., the DHS NETStudy 2.0 website indicated ULP-K was affiliated with the licensee February 17, 2023, and separated from the licensee March 4, 2023. The website further indicated ULP-K was affiliated with the licensee May 1, 2023. Both listings indicated ULP-K required direct supervision.</p> <p>On May 2, 2023, at 1:49 p.m., ULP-J stated ULP-K worked independently in all units of the facility, and assisted residents with medication administration and cares.</p> <p>On May 2, 2023, at 1:59 p.m., ULP-N stated they thought ULP-K was not in training anymore. ULP-N further stated ULP-K sometimes worked as a "float", helping with 2-person transfers, cleaning wheelchairs, and setting up the dining room in each cottage for breakfast.</p> <p>On May 2, 2023, at 2:36 p.m., director of nursing (DON)-D stated ULP-K had been working on their own. DON-D stated she was not involved in deciding how long the ULPs were scheduled to train and follow ("shadow") another ULP. DON-D further stated she was not involved in the BGS process and the licensed assisted living director (LALD) and administrative staff managed that process.</p> <p>On May 2, 2023, at 2:34 p.m., the survey supervisor contacted the DHS NETStudy 2.0 call center by phone. DHS-M, a DHS NETStudy 2.0</p>	{01290}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01290}	<p>Continued From page 16</p> <p>call center representative, and supervisor reviewed the Final Registry Results Form from DHS dated May 1, 2023, and the NETStudy 2.0 website data from May 2, 2023. DHS-M stated an application was submitted for ULP-K on May 1, 2023, and the letter and website both identify ULP-K required supervision. DHS-M stated the Final Registry Results Form was part of the BGS process, and not a clearance to work unsupervised. DHS-M stated although the application was submitted, the background study was not completed, adding because ULP-K was required to submit fingerprints and complete the Consent and Disclosure form; DHS-M described the Consent and Disclosure form was where the ULP disclosed and attested if they had any convictions and authorized completion of the BGS. DHS-M stated these two pieces of required information, would have been emailed directly to ULP-K shortly after the application was submitted, and added the BGS could not be completed until they were received by DHS. DHS-M further stated ULP-K was identified to require supervision and the facility should check the website to determine if supervision was required.</p> <p>On May 2, 2023, at 5:14, p.m., LALD-C stated ULP-K was hired in February, but left employment briefly and they discharged her file March 4, 2023. LALD-C stated their office manager was responsible for letting them know if the BGS was cleared or not, but was fairly new to the role. LALD-C further stated they initiated employee audits and found one employee (unnamed), at that time, that did not have a cleared BGS. LALD-D stated they did not find any issue with ULP-K's BGS until the surveyor requested the documentation, and further stated they were not aware NETStudy 2.0 indicated ULP-K required</p>	{01290}		
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Minnesota Department of Health

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{01290}	<p>Continued From page 17</p> <p>supervision while working.</p> <p>The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would complete pre-employment BGS required for all employees.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On May 2, 2023, at 6:25 p.m., an immediate correction order was issued for licensing order 1290.</p> <p>On May 3, 2023, at 11:52 a.m. the immediacy of the correction order was removed; the scope and level remain unchanged.</p>	{01290}		
{01940} SS=D	<p><b>144G.72 Subd. 3 Individualized treatment or therapy managemen</b></p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:</p> <p>(1) a statement of the type of services that will be provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or</p>	{01940}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01940}	<p>Continued From page 18</p> <p>appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>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) developed a treatment or therapy management plan to include all required content for one of one resident (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's RN assessment, dated February 15, 2023,</p>	{01940}		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01940}	<p>Continued From page 19</p> <p>indicated R5's recommended diet was, "Regular, Regular- Nectar Thick," and indicated "Complies with diet -specify: Nectar thick liquids". The assessment further indicated, under the Treatment Therapy section, "no treatments required".</p> <p>R5's Order Summary Report, provided upon admission, signed December 27, 2022, by R5's provider indicated, "Regular diet Mechanical Soft texture, Nectar consistency, Nectar thick liquids via open cup, nose cup, or straw".</p> <p>R5's physician's order signed January 9, 2023, by R5's provider indicated, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>R5's service plans, signed December 29, 2022, and updated May 1, 2023 (unsigned), both lacked information related to assistance with the therapeutic use of thickened liquids.</p> <p>R5's record lacked a treatment or therapy management plan for the provider-ordered thickener, to include:</p> <ul style="list-style-type: none"> <li>- a statement of the type of services that will be provided;</li> <li>- documentation of specific resident instructions relating to the treatments or therapy administration;</li> <li>- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</li> <li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li> <li>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of</li> </ul>	{01940}		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01940}	<p>Continued From page 20</p> <p>treatment or therapy to prevent possible complications or adverse reactions.</p> <p>The licensee's correction order documentation in response to the order issued on a routine licensing survey ending February 17, 2023, indicated order 1940 was corrected March 28, 2023, and indicated "immediately corrected," and "[director of clinical services] DCS will ensure that all service plans and residents care plan accurately reflects all treatments and services delivered to residents."</p> <p>On May 3, 2023, at 11:38 a.m., DON-D stated via telephone, unlicensed personnel (ULPs) "know to use the scoop that is provided and have the instruction on the amt to put in the liquid based on manufacturer directions." When asked if there was a treatment or therapy management plan with those instructions documented on the service plan or elsewhere, DON-D stated they might have had it on another paper and that she would look for it.</p> <p>On May 3, 2023, at 4:27 p.m., DON-D stated via email, "For [R5], her profile indicates nectar thick liquids. Verbal training was provided to staff on how to use thick it to obtain nectar consistency".</p> <p>On May 4, 2023, at 10:21 a.m., licensed assisted living director (LALD)-C indicated DON-D had been spending time making corrections in the deficient areas identified in the survey ending February 17, 2023, and had not been able to complete all corrections.</p> <p>The licensee's 7.05 Treatment &amp; Therapy Management Plan policy, revised March 28, 2023, indicated, "For each resident at [licensee] receiving management of ordered or prescribed</p>	{01940}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01940}	Continued From page 21  treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." The policy further indicated, "[Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions."  No further information provided.	{01940}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy  Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	{01950}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/04/2023</b>
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{01950}	<p>Continued From page 22</p> <p>or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:</p> <p>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</p> <p>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) specified, in writing, specific instructions for each delegated treatment or therapy task, and documented those instructions in the resident's record for one of one resident (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include: R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's RN assessment, dated February 15, 2023,</p>	{01950}		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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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
{01950}	<p>Continued From page 23</p> <p>indicated R5's recommended diet was, "Regular, Regular- Nectar Thick," and indicated "Complies with diet -specify: Nectar thick liquids". The assessment further indicated, under the Treatment Therapy section, "no treatments required".</p> <p>R5's Order Summary Report, provided upon admission, signed December 27, 2022, by R5's provider indicated, "Regular diet Mechanical Soft texture, Nectar consistency, Nectar thick liquids via open cup, nosey cup, or straw".</p> <p>R5's physician's order signed January 9, 2023, by R5's provider indicated, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>R5's record lacked a treatment or therapy management plan with all required content for the provider-ordered thickener.</p> <p>Unlicensed personnel (ULP)-F was hired April 18, 2016, and began providing direct assisted living services August 1, 2021.</p> <p>R5's Service Recap Summary for April 1 through May 3, 2023, indicated ULP-F assisted R5 with meals on April 26, 28, and May 1-3.</p> <p>ULP-F's record lacked documentation the RN trained and evaluated ULP-F's competency to perform the delegated task of administering thickened liquids to R5, including: -instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures.</p> <p>R5's record lacked evidence the RN provided instruction for ULPs administering thickened</p>	{01950}		

Minnesota Department of Health

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{01950}	<p>Continued From page 24</p> <p>liquids, including: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's record.</p> <p>The licensee's correction order documentation in response to the order issued on the licensing survey ending February 17, 2023, indicated order 1950 was corrected March 28, 2023, and indicated, "Director of clinical services will review [sic] ensure a review of residents service plan and ensure that all services are on caregivers task list".</p> <p>On May 3, 2023, at 11:38 a.m., DON-D stated via telephone, unlicensed personnel (ULPs) "know to use the scoop that is provided and have the instruction on the amt to put in the liquid based on manufacturer directions." When asked if there was a treatment or therapy management plan with those instructions documented on the service plan or elsewhere, DON-D stated they might have had it on another paper and that she would look for it.</p> <p>On May 3, 2023, at 4:27 p.m., DON-D stated via email, "For [R5], her profile indicates nectar thick liquids. Verbal training was provided to staff on how to use thick it to obtain nectar consistency".</p> <p>On May 4, 2023, at 10:21 a.m., licensed assisted living director (LALD)-C indicated DON-D had been spending time making corrections in the deficient areas identified in the survey ending February 17, 2023, and had not been able to complete all corrections.</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy, revised April 21, 2023, indicated, "Staff who provide delegated nursing or</p>	{01950}		

Minnesota Department of Health

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{01950}	Continued From page 25  therapy tasks to residents at Prelude Homes and Services will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person ' s ability perform the tasks.  No further information provided.	{01950}		
{02040} SS=F	<b>144G.81 Subdivision 1 Fire protection and physical environment</b>  An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.  This MN Requirement is not met as evidenced by: No further action needed.	{02040}		



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

Electronically Delivered

March 22, 2023

Licensee

Prelude Homes & Services LLC

4650 White Bear Parkway

White Bear Lake, MN 55110

RE: Project Number(s) SL32276015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

#### **LICENSING ORDERS**

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

**St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00**

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00**

**St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$3,000.00**

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

**The total amount you are assessed is \$9,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

**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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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

Sincerely,



Jess Schoenecker, Supervisor  
State Evaluation Team  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Email: Jess.Schoenecker@state.mn.us  
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p><b>INITIAL COMMENTS:</b> SL32276015</p> <p>On February 13 through February 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 27 active residents receiving services under the Assisted Living with Dementia Care license.</p> <p>On February 15, 2023, the immediacy of correction orders 0470, 1750, and 2310 has been removed, however non-compliance remains at a scope and level of I, I, and G, respectively.</p> <p>*****REVISED*****</p> <p>As a result of a settlement agreement this form has been revised. Specifically tag cited at 0470 has been rescinded in its entirety.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 480 SS=F	<b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b>	0 480		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	<p>Continued From page 1</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 the residents).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 13, 2023, for the specific Minnesota Food Code deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 480		
0 510 SS=F	<p>144G.41 Subd. 3 Infection control program</p> <p>(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.</p>	0 510		

Minnesota Department of Health

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0 510	<p>Continued From page 2</p> <p>(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.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.)</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 7:20 a.m., medication administration to multiple residents, unlicensed personnel (ULP)-F was observed donning (putting on) and doffing (taking off) gloves without completing hand hygiene by either using hand sanitizer or washing their hands. ULP-F had donned gloves to set up medications for administration including crushing the medications and mixing into apple sauce,</p>	0 510		
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Minnesota Department of Health

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0 510	<p>Continued From page 3</p> <p>then doffing the gloves prior to providing the medications to residents without performing hand hygiene.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-G stated licensee's expectations are all staff will perform hand hygiene before and after glove use. DON-G stated ULPs had all been trained in appropriate glove use which included hand hygiene when donning and doffing gloves, but was unsure why the ULP had not performed the required hand hygiene.</p> <p>The licensee's 8.07 Gloves policy dated August 1, 2021, indicated all employees would perform hand hygiene before donning and after doffing gloves.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(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;</p>	0 680		

Minnesota Department of Health

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0 680	<p>Continued From page 4</p> <p>(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 working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and prominently post their emergency disaster plan. This had the potential to affect all residents, employees, and visitors to the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On February 13, 2023, at approximately 10:00 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location.</p>	0 680		

Minnesota Department of Health

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0 680	<p>Continued From page 5</p> <p>On February 14, 2023, at approximately 11:00 a.m., licensed assisted living director (LALD)-C stated the licensee had failed to develop a disaster or emergency preparedness plan with all required content.</p> <p>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.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable</p>	0 790		

Minnesota Department of Health

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0 790	<p>Continued From page 6</p> <p>fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On February 14, 2023, approximately from 10:45 a.m. to 1:00 p.m. survey staff toured the facility with the maintenance director (M)-H. During the tour, survey staff observed the portable fire extinguishers throughout the facility had been tagged with an annual service date of October 2022 but lacked records to show the monthly visual inspections. Survey staff explained to the M-H that the portable fire extinguishers must also be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. The M-H verified the findings.</p> <p>On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the M-H, the licensed assisted living director (LALD)-C, and the LALD-G acknowledged the above findings.</p> <p>No further information was provided.</p>	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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0 790	Continued From page 7	0 790		
0 800 SS=F	<p><b>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</b></p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On February 14, 2023, approximately from 10:45 a.m. to 1:00 p.m. survey staff toured the facility with the maintenance director (M)-H.</p> <p>During the tour, survey staff observed the following:</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 800	<p>Continued From page 8</p> <p>1. The exterior walkways were not maintained in the means of egress from the building to the roadway within the courtyard areas. -The exterior walkways serving the marked exit doors from the dining rooms (Peace, King, and Compassionate) through the courtyards had snow cover to the courtyard gate connecting to the roadway. The M-H verified the findings and stated that he will reach out to the company to extend the snow removal areas to include the means of egress in the courtyard areas. -The exterior walkway concrete slabs in the means of egress in the courtyard had uneven surfaces in multiple areas outside of the marked exit doors creating tripping hazards during an evacuation emergency (approximately 3/4 inch drop in the concrete slab). In addition, the drop in the concrete slab creating uneven surfaces in the walkway creates tripping hazards for residents during the recreational use of the courtyard.</p> <p>2. The licensee failed to secure chemicals to protect memory care residents from harm. -In the Compassionate kitchenette cabinet common area, a variety and large jugs of cleaning chemicals were stored and not secured from resident access. No staff was observed in the kitchenette area at the time. -In the Compassionate laundry room, large detergents and chemicals were stored and not secured and keyed laundry room was not locked from resident access. No employee was observed in the laundry room or near the laundry room at the time. The M-H verified locked up the laundry room during the tour.</p> <p>3. The chemical soap dispensers connected to the faucets of the mop sinks were not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply.</p>	0 800		

Minnesota Department of Health

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0 800	Continued From page 9  The above findings were visually verified by the M-H accompanying the tour.  On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the M-H, the licensed assisted living director (LALD)-C, and the LALD-G acknowledged the above findings.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 10</p> <p>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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 1:10 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-G. At approximately 1:50 p.m., document review and interview with the LALD-G and LALD-C indicated the following:</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 11</p> <p>1. The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. The minimum required employee training is upon hire and twice a year for fire safety and evacuation. No record was available or provided for review. The LALD-C stated that this training is being scheduled.</p> <p>2. The licensee lacked fire evacuation drill records. The fire drill record provided for the review was a calendar with logged dates and shifts for the first half of the year 2022 and no details of evacuation drill information. Drill dates documented were 1/1/2022 (1st shift), 4/22/2022 (1st shift), 4/21/2022 (2nd and 3rd shift), and 6/1/2022 (2nd shift). Survey staff explained to the LALD-C and the LALD-G that the licensee failed to perform any evacuation drills in the second half of the year 2022 and no drills performed in 2023 to date. The minimum required frequency of two evacuation drills for employees is twice per year per shift with at least one evacuation every other month. The LALD-C confirmed with the findings and commented that they did have a fire drill scheduled for the next day.</p> <p>On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the licensed assisted living director (LALD)-C and the LALD-G acknowledged the above findings.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 810		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 970	<p>Continued From page 12</p> <p>property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 of the residents).</p> <p>The findings include:</p> <p>On February 13, 2023, at approximately 10:00 a.m., licensed assisted living director (LALD)-C provided the licensee's blank Assisted Living Contract: Terms &amp; Conditions and indicated the document was the licensee's assisted living contract used for all residents.</p> <p>The assisted living contract read in section 25. Liability, "Provider is not liable to Resident ... for any injury, death or property damage occurring in the Suite or on Provider's premises unless such injury, death or property damage occurs as the</p>	0 970		
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Minnesota Department of Health

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0 970	<p>Continued From page 13</p> <p>result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents."</p> <p>On February 15, 2023, at 12:00 p.m., LALD-C indicated the licensee's assisted living contract included language waiving licensee's liability for health, safety, and personal property of the residents. LALD-C indicated the licensee was not aware of the prohibition for waivers of liability.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 970		
01290 SS=C	<p><b>144G.60 Subdivision 1 Background studies required</b></p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01290	<p>Continued From page 14</p> <p>background study (BGS) was submitted and a clearance received in affiliation with the assisted living with dementia care license for two of two employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A was hired August 11, 2022.</p> <p>LPN-A's record included Department of Human Services Background Study Clearance letter dated December 27, 2022, associated with licensee's expired Health Facility Identification (HFID) license number 27917.</p> <p>ULP-B was hired on April 25, 2022.</p> <p>ULP-B's record included Department of Human Services Background Study Clearance letter dated May 6, 2022, associated with licensee's expired Health Facility Identification (HFID) license number 27917.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B performed resident cares which included medication administration and activities of daily living.</p> <p>LPN-A and ULP-B's employee records lacked evidence of current, cleared BGS affiliated with</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01290	<p>Continued From page 15</p> <p>the licensee's current assisted living with dementia care license #32276, effective August 1, 2021.</p> <p>On February 15, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C indicated the BGS for many of the licensee's employees were under the former comprehensive license versus the new assisted living license. LALD-C indicated the BGS were conducted at the corporate office associated with the expired HFID and not under the current HFID for the active assisted living with dementia care license.</p> <p>The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would complete pre-employment BGS required for all employees, but failed to indicate the BGS would be completed under the licensee's current HFID..</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
01440 SS=F	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(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</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01440	<p>Continued From page 16</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed by a registered nurse within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B was hired on April 25, 2022.</p> <p>ULP-B's Skill Competency Medication Administration - Routes dated May 27, 2022, indicated ULP-B was trained and found competent by the signature of a licensed practical</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01440	<p>Continued From page 17</p> <p>nurse (LPN).</p> <p>ULP-B's training record lacked documentation a registered nurse (RN) trained, delegated, and then supervised within 30 calendar days the delegated task of medication administration.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B performed resident cares which included the delegated task of medication administration.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-D indicated ULP-B was trained by an LPN and not an RN as required per statute. DON-D stated a 30-day RN supervision was not documented in ULP-B's record and would need to be completed. LALD-C indicated the licensee had a period of time in which an LPN was providing training and supervision of staff while RN staffing was short.</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated a RN would complete direct supervision within 30 days of the task being delegated to a ULP.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01440		
01470 SS=F	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p> <p>(1) an overview of this chapter;</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01470	<p>Continued From page 18</p> <p>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</p> <p>(3) handling of emergencies and use of emergency services;</p> <p>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</p> <p>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01470	<p>Continued From page 19</p> <p>and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A and ULP-B were hired August 11, 2022, and April 25, 2022, respectively.</p> <p>LPN-A and ULP-B's records included My Transcript documents identified by licensed assisted living director (LALD)-C as the documents all training both LPN-A and ULP-B had completed.</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01470	<p>Continued From page 20</p> <p>LPN-A and ULP-B's training transcripts lacked documentation of the following:</p> <ul style="list-style-type: none"> <li>- an overview of this chapter;</li> <li>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</li> <li>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</li> <li>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and</li> <li>-consumer advocacy services; and review of types of assisted living services the employee will provide and provider's scope of license.</li> </ul> <p>On February 15, 2023, at 12:00 p.m., LALD-C indicated the licensee had failed to assign the required training within the licensee's selected training program.</p> <p>The licensee's policy 5.01, Orientation of Staff and Supervisors &amp; Content policy dated August 1, 2021, indicated all staff would have the required training completed prior to providing services to residents.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470		
01620 SS=E	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01620	<p>Continued From page 21</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day reassessment and ongoing resident monitoring and reassessment not to exceed 90 days from the previous assessment for two of three residents (R2, R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01620	<p>Continued From page 22</p> <p>than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R2 was admitted on April 4, 2019.</p> <p>R2's record contained an Assessment As Of Date dated November 11, 2022, indicated by licensed assisted living director (LALD)-C as R2's most recent assessment. R2's record contained no further assessments.</p> <p>R4 was admitted on January 26, 2023.</p> <p>R4's record contained an Assessment As Of Date dated January 26, 2023, was identified by LALD-C as R4's most recent and admission assessment. R4's record contained no further assessments.</p> <p>On February 15, 2023, at approximately 12:00 p.m., director of nursing (DON)-D indicated the licensee was aware some resident assessments were not completed within the required timeframes. DON-D indicated the licensee was aware of all required assessment time frames.</p> <p>The licensee's 6.01 Assessments, Reviews &amp; Monitoring policy dated August 1, 2021, indicated the RN conduct a nursing assessment of physical and cognitive needs and reassessment conducted no more than 14 calendar days after initiation of services and ongoing cannot exceed 90 calendar days from the last date of the assessment.</p> <p>No further information provided.</p>	01620		

Minnesota Department of Health

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01620	Continued From page 23  TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan or revisions included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for two of three residents (R2, R3).</p>	01640		

Minnesota Department of Health

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01640	<p>Continued From page 24</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>R2 was admitted on March 4, 2019.</p> <p>R2's signed Resident Service Plan dated March 4, 2019, included fourteen services to be provided.</p> <p>R2's unsigned current Resident Service Plan dated February 14, 2023, included twenty-seven services to be provided.</p> <p>R3 admitted on March 10, 2016.</p> <p>R3's signed Resident Service Plan dated January 1, 2016, included twelve services to be provided.</p> <p>R3's unsigned current Resident Service Plan dated February 14, 2023, included twenty-four services to be provided.</p> <p>R2 and R3's unsigned Resident Service Plans provided by licensed assisted living director (LALD)-C and indicated as R2 and R3's current service plans, lacked a signature or authentication by the licensee or by the resident or resident's representative.</p> <p>On February 15, 2023, at approximately 12:00</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01640	<p>Continued From page 25</p> <p>p.m., LALD-C indicated R2 and R3's service plan lacked authentication by the licensee or by the resident or resident's representative. LALD-C stated the service plan should have included the required authentication and maintained in the resident's record.</p> <p>The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated all service plans and revisions would include a signature or authentication by the licensee or by the resident or resident's representative.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01700 SS=F	<p><b>144G.71 Subd. 2 Provision of medication management services</b></p> <p>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions needed in management of medications to prevent</p>	01700		

Minnesota Department of Health

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01700	<p>Continued From page 26</p> <p>diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R2, R3, R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p> <p>The findings include:</p> <p>On February 13, 2023, during entrance conference, director of nursing (DON)-D stated resident assessments are filled in by a licensed practical nurse (LPN) and DON-D reviewed and signed assessments as completed.</p> <p>R2, R3, and R4's Assessment As of Date identified by DON-D as R2, R3, and R4's current assessments and included all required content for each resident's medication management record</p>	01700		

Minnesota Department of Health

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01700	<p>Continued From page 27</p> <p>were all digitally signed by DON-D as completed. R2, R3, and R4's assessment all indicated each resident received medication management as a service and included all required content for a medication management record.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and DON-D stated the licensee's current practice for all assessments was to have the LPN complete the assessment form in the licensee's electronic health record (EHR), and then the RN would log into the EHR to review the LPN's assessment form information and then sign off the assessment as completed. LALD-C and DON-D indicated the licensee thought an LPN could gather all the assessment data and the RN reviewing it would meet the requirement for the assessment, however DON-D stated this meant the RN was not completing the assessment and the medication management record face to face as required.</p> <p>The licensee's 7.01 Medication Management - Assessment, Monitoring &amp; Reassessment policy dated August 1, 2021, originally indicated under "Procedure," assessments for medication management would be conducted face-to-face, the licensee had highlighted and crossed out the words, "face-to-face."</p> <p>The licensee's 6.01 Assessments, Reviews &amp; Monitoring policy dated August 1, 2021, indicated assessments would be conducted in person.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01750	Continued From page 28	01750		
01750 SS=I	<p><b>144G.71 Subd. 7 Delegation of medication administration</b></p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <ul style="list-style-type: none"> <li>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</li> <li>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and</li> <li>(3) communicated with the unlicensed personnel about the individual needs of the resident.</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) completed competency evaluations for the delegated task of medication administration for two of two unlicensed personnel ((ULP)-B and ULP-F).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B was hired April 5, 2022.</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01750	<p>Continued From page 29</p> <p>ULP-B's Skill Competency dated May 27, 2022, indicated ULP-B was competent for all medication routes the licensee delegated to ULPs and signed by a licensed practical nurse (LPN).</p> <p>ULP-F was hired April 18, 2016.</p> <p>ULP-F's Skill Competency dated July 2, 2020, indicated ULP-F was competent for all medication routes the licensee delegated to ULPs by a LPN.</p> <p>On February 14, 2023, at approximately 7:00 a.m., the surveyor observed ULP-B and ULP-F provide the delegated task of medication administration to multiple residents during the licensee's morning medication administration time including oral medications and eye drops.</p> <p>On February 14, 2023, at approximately 1:15 p.m., licensed assisted living director (LALD)-C stated the licensee previously had a LPN provide the competency training to ULPs. LALD-C stated the licensee recently changed to having only a RN, as required by statute, provide competency to ULPs, but had not re-trained those who received competency training from a LPN.</p> <p>The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations of ULPs would be conducted by a RN.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On February 15, 2023, the immediacy of correction order 1750 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01750	Continued From page 30  level of I.	01750		
01790 SS=F	<p><b>144G.71 Subd. 10 Medication management for residents who will</b></p> <p>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;</p> <p>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and</p> <p>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.</p> <p>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:</p> <p>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and</p> <p>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:</p> <p>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;</p> <p>(ii) how the container or containers must be labeled;</p> <p>(iii) written information about the medications to</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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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
01790	<p>Continued From page 31</p> <p>be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide training to unlicensed personnel ((ULP)-B) for giving accurate and current medications for those residents who received medication management services during unplanned times away from home. This has the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01790	<p>Continued From page 32</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B was hired on April 25, 2022.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B provided medication administration to R2 and R3.</p> <p>ULP-B's record lacked documentation they were trained, delegated, and supervised on the licensee's policy and procedure for management of medication for residents who may have unplanned times away from home.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-D stated the licensee does not train any ULPs for handling unplanned times away. DON-D stated ULPs were to contact the on-call nurse for any unplanned times away to receive direction on medication preparation, so no ULP had received training or supervision for the delegated task.</p> <p>The licensee's 7.10 Medication Management - Planned &amp; Unplanned Time Away policy dated August 1, 2021, indicated if licensee was providing medication management, ULPs would be trained and supervised for management for unplanned times away from home.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01940	Continued From page 33	01940		
01940 SS=D	<p><b>144G.72 Subd. 3 Individualized treatment or therapy managemen</b></p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:</p> <ul style="list-style-type: none"> <li>(1) a statement of the type of services that will be provided;</li> <li>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</li> <li>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</li> <li>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li> <li>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management record to include all required</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01940	<p>Continued From page 34</p> <p>content for one of two residents (R5) who had a treatment.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's Assessment As Of Date dated December 28, 2022, read under section Eating -Dietary, "Recommended idea (select from list) Regular, Regular - Nectar Thick. Complies with diet - specify: Nectar thick liquids."</p> <p>R5's physician's order signed January 9, 2023, by R5's provider read, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>On February 14, 2023, at approximately 6:50 a.m., observed a white with yellow top container labeled, "Thick-It," name brand with R5's name printed on the cover sitting on the counter in R5's secured unit kitchen counter. Unlicensed personnel (ULP)-F indicated container was used per the manufacturer's instructions for all of R5's liquids.</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01940	<p>Continued From page 35</p> <p>R5's record lacked a treatment plan with all required content for the provider ordered thickener.</p> <p>On February 14, 2023, at approximately 1:45 p.m., licensed assisted living director (LALD)-C indicated licensee was not aware provider ordered thickener required a treatment plan. LALD-C stated a treatment plan was not developed or implemented for R5 related to their thickener.</p> <p>The licensee's 7.05 Treatment &amp; Therapy Management Plan policy dated August 1, 2021, indicated a treatment plan with all required content would be developed and implemented for all ordered or prescribed treatments and therapy services.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
01950 SS=D	<p>144G.72 Subd. 4 Administration of treatments and therapy</p> <p>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:</p>	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01950	<p>Continued From page 36</p> <p>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</p> <p>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) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5) who had an ordered treatment.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's Assessment As Of Date dated December 28, 2022, read under section Eating -Dietary, "Recommended idea (select from list) Regular, Regular - Nectar Thick. Complies with diet -</p>	01950		
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Minnesota Department of Health

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01950	<p>Continued From page 37</p> <p>specify: Nectar thick liquids."</p> <p>R5's physician's order signed January 9, 2023, by R5's provider read, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>On February 14, 2023, at approximately 6:50 a.m., observed a white with yellow top container labeled, "Thick-It," name brand with R5's name printed on the cover sitting on the counter in R5's secured unit kitchen counter. Unlicensed personnel (ULP)-F indicated container was used per the manufacturer's instructions for all of R5's liquids when R5 was provided liquids.</p> <p>R5's record lacked a treatment plan the RN provided with:</p> <ul style="list-style-type: none"> <li>- instruction to the unlicensed personnel in the proper methods with respect to each resident and documented the unlicensed personnel has demonstrated the ability to competently follow the procedures;</li> <li>- specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</li> <li>- communicated with the unlicensed personnel about the individual needs of the resident.</li> </ul> <p>On February 14, 2023, at approximately 1:45 p.m., licensed assisted living director (LALD)-C indicated licensee was not aware provider ordered thickener required a treatment plan. LALD-C stated a treatment plan was not developed or implemented for R5 related to their thickener. Director of nursing (DON)-D stated a treatment had not been developed and the ULPs had not been provided specific instruction other than the manufacturer's instruction on the side of the container.</p>	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01950	<p>Continued From page 38</p> <p>The licensee's 7.05 Treatment &amp; Therapy Management Plan policy dated August 1, 2021, indicated a treatment plan with all required content would be developed and implemented for all ordered or prescribed treatments and therapy services.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01950		
02040 SS=F	<p><b>144G.81</b> Subdivision 1 Fire protection and physical environment</p> <p>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.</p>	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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02040	<p>Continued From page 39</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 2:00 p.m., a documentation review and interview were performed with the licensed assisted living director (LALD)-G and LALD-C on the hazard vulnerability assessment and mitigation plan for the memory care physical environment of the property. Based on the document review and interview, the licensee failed to provide a site-specific hazard vulnerability (safety risk) assessment and mitigation plan to protect the memory care residents from harm. During the interview, the LALD-G and the LALD-C confirmed that they had not developed the plan but were currently working on developing it. This finding was evident as there was no site-specific plan documentation provided for review.</p> <p>On February 14, 2023, at approximately 2:15 p.m., survey staff discussed the observations and findings and explained to the LALD-C and the LALD-G that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm.</p> <p>No further information was provided.</p>	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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02040	Continued From page 40  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=G	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p> <p>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 standards, medical or nursing standards for one of one resident (R2) who utilized bed rails.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2 admitted on March 4, 2019.</p> <p>R2's Assessment As Of Date dated November 14, 2022, indicated R2 used an electric bed with a partial side rail attached to bed.</p> <p>R2's record lacked the following information:</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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02310	<p>Continued From page 41</p> <ul style="list-style-type: none"> <li>- the side rails use/need assessment;</li> <li>- the purpose and intention of the side rails;</li> <li>- documentation of the risks vs. benefits discussion with the resident or responsible party;</li> <li>- measurements completed and documented; and</li> <li>- the side rails were Food and Drug Administration (FDA) compliant.</li> </ul> <p>On February 14, 2023, at approximately 7:20 a.m., the surveyor observed R2's bed with hospital style side rail in place.</p> <p>On February 14, 2023, at approximately 12:00 p.m., licensed assistant living director (LALD)-C and director of nursing (DON)-D stated if a side rail assessment were to be completed, it would be in the resident's assessment.</p> <p>The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated all identified assessment areas would be completed prior to side rail use for the safety of the resident.</p> <p>The FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated the above lacking areas of licensee's assessment would be required to be completed for the safety of the resident that utilized side rails.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On February 15, 2023, the immediacy of correction order 2310 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and level of G.</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p><b>INITIAL COMMENTS:</b> SL32276015</p> <p>On February 13 through February 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 27 active residents receiving services under the Assisted Living with Dementia Care license.</p> <p>On February 15, 2023, the immediacy of correction orders 0470, 1750, and 2310 has been removed, however non-compliance remains at a scope and level of I, I, and G, respectively.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 470 SS=I	<p><b>144G.41 Subdivision 1 Minimum requirements</b></p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p>	0 470		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 470	<p>Continued From page 1</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the potential to affect all residents.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to</p>	0 470		

Minnesota Department of Health

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0 470	<p>Continued From page 2</p> <p>serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Licensee's facility was designed as one large building with a common locked entrance and three (3) seperate locked units off a common hallway where staff offices, spa, visitor bathrooms, and chapel were located. Each seperate unit was independent from each other and entire facility was licensed as an assisted living facility with dementia care.</p> <p>R2 was admitted on March 4, 2019.</p> <p>R2's Assessment As Of Date dated November 14, 2022, identified by licensed assisted living director (LALD)-C as R2's most recent registered nurse (RN) assessment, read under the Mobility - Transfer section, "Needs two people to transfer," and "Needs adaptive equipment to transfer (select from list) Other - specify: EZ Stand," (a mechanical device used with a sling to lift a person from a seated position to another seated position).</p> <p>On February 13, 2023, at 10:00 a.m., during the entrance conference, LALD-C indicated the licensee staffed one person in each of the three secured memory care units. Additionally, LALD-C provided licensee's Weekly Schedule: February 12, 2023 - February 18, 2023, which indicated a single staff member would be present in each secured memory care unit named E Peace, M King, and W Compassion from the hours of 11:00 p.m. through 7:00 a.m. (commonly called the</p>	0 470		
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Minnesota Department of Health

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0 470	<p>Continued From page 3</p> <p>overnight hours).</p> <p>On February 13, 2023, at approximately 6:50 a.m., unlicensed personnel (ULP)-E, who worked the overnight hours, indicated if a resident sustained a fall, a mechanical lift that required two people would be used to get the resident off the floor.</p> <p>On February 13, 2023, at approximately 7:00 a.m., ULP-F stated R2 required a 2-person transfer for all transfers with the use of an EZ-Stand. The surveyor observed R2 had an EZ Stand device in their bathroom and sling noted on the EZ Stand.</p> <p>On February 14, 2023, at 11:15 a.m., LALD-C stated if a resident required a 2-person transfer during the overnight hours, staff would leave one of the secured units, leaving it unattended without staff, and go assist the resident and staff member who required a 2-person transfer.</p> <p>The licensee's 4.06 Staffing &amp; Scheduling policy dated August 1, 2021, read, "The Housing Director must ensure that staffing levels are adequate to address the following: c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On February 15, 2023, the immediacy of correction order 0470 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and level of I.</p>	0 470		

Minnesota Department of Health

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0 480 SS=F	<p><b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b></p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 the residents).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 13, 2023, for the specific Minnesota Food Code deficiencies.</p> <p><b>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</b></p>	0 480		
0 510 SS=F	<p><b>144G.41 Subd. 3 Infection control program</b></p> <p>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and</p>	0 510		

Minnesota Department of Health

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0 510	<p>Continued From page 5</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.)</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 7:20 a.m., medication administration to multiple residents, unlicensed personnel (ULP)-F was observed donning (putting on) and doffing (taking off) gloves without completing hand hygiene by either using hand sanitizer or washing their hands. ULP-F had donned gloves to set up medications for administration including crushing</p>	0 510		

Minnesota Department of Health

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0 510	<p>Continued From page 6</p> <p>the medications and mixing into apple sauce, then doffing the gloves prior to providing the medications to residents without performing hand hygiene.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-G stated licensee's expectations are all staff will perform hand hygiene before and after glove use. DON-G stated ULPs had all been trained in appropriate glove use which included hand hygiene when donning and doffing gloves, but was unsure why the ULP had not performed the required hand hygiene.</p> <p>The licensee's 8.07 Gloves policy dated August 1, 2021, indicated all employees would perform hand hygiene before donning and after doffing gloves.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(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</p>	0 680		

Minnesota Department of Health

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0 680	<p>Continued From page 7</p> <p>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 working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and prominently post their emergency disaster plan. This had the potential to affect all residents, employees, and visitors to the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On February 13, 2023, at approximately 10:00 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent</p>	0 680		

Minnesota Department of Health

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0 680	<p>Continued From page 8</p> <p>location.</p> <p>On February 14, 2023, at approximately 11:00 a.m., licensed assisted living director (LALD)-C stated the licensee had failed to develop a disaster or emergency preparedness plan with all required content.</p> <p>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.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, record review, and</p>	0 790		

Minnesota Department of Health

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0 790	<p>Continued From page 9</p> <p>interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On February 14, 2023, approximately from 10:45 a.m. to 1:00 p.m. survey staff toured the facility with the maintenance director (M)-H. During the tour, survey staff observed the portable fire extinguishers throughout the facility had been tagged with an annual service date of October 2022 but lacked records to show the monthly visual inspections. Survey staff explained to the M-H that the portable fire extinguishers must also be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. The M-H verified the findings.</p> <p>On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the M-H, the licensed assisted living director (LALD)-C, and the LALD-G acknowledged the above findings.</p>	0 790		
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Minnesota Department of Health

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0 790	Continued From page 10  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On February 14, 2023, approximately from 10:45 a.m. to 1:00 p.m. survey staff toured the facility with the maintenance director (M)-H.</p> <p>During the tour, survey staff observed the</p>	0 800		

Minnesota Department of Health

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0 800	<p>Continued From page 11</p> <p>following:</p> <p>1. The exterior walkways were not maintained in the means of egress from the building to the roadway within the courtyard areas.</p> <p>-The exterior walkways serving the marked exit doors from the dining rooms (Peace, King, and Compassionate) through the courtyards had snow cover to the courtyard gate connecting to the roadway. The M-H verified the findings and stated that he will reach out to the company to extend the snow removal areas to include the means of egress in the courtyard areas.</p> <p>-The exterior walkway concrete slabs in the means of egress in the courtyard had uneven surfaces in multiple areas outside of the marked exit doors creating tripping hazards during an evacuation emergency (approximately 3/4 inch drop in the concrete slab). In addition, the drop in the concrete slab creating uneven surfaces in the walkway creates tripping hazards for residents during the recreational use of the courtyard.</p> <p>2. The licensee failed to secure chemicals to protect memory care residents from harm.</p> <p>-In the Compassionate kitchenette cabinet common area, a variety and large jugs of cleaning chemicals were stored and not secured from resident access. No staff was observed in the kitchenette area at the time.</p> <p>-In the Compassionate laundry room, large detergents and chemicals were stored and not secured and keyed laundry room was not locked from resident access. No employee was observed in the laundry room or near the laundry room at the time. The M-H verified locked up the laundry room during the tour.</p> <p>3. The chemical soap dispensers connected to the faucets of the mop sinks were not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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0 800	Continued From page 12  potable water supply.  The above findings were visually verified by the M-H accompanying the tour.  On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the M-H, the licensed assisted living director (LALD)-C, and the LALD-G acknowledged the above findings.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 810	<p>Continued From page 13</p> <p>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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 1:10 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-G. At approximately 1:50 p.m., document review and interview with the LALD-G and LALD-C indicated the following:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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0 810	<p>Continued From page 14</p> <p>1. The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. The minimum required employee training is upon hire and twice a year for fire safety and evacuation. No record was available or provided for review. The LALD-C stated that this training is being scheduled.</p> <p>2. The licensee lacked fire evacuation drill records. The fire drill record provided for the review was a calendar with logged dates and shifts for the first half of the year 2022 and no details of evacuation drill information. Drill dates documented were 1/1/2022 (1st shift), 4/22/2022 (1st shift), 4/21/2022 (2nd and 3rd shift), and 6/1/2022 (2nd shift). Survey staff explained to the LALD-C and the LALD-G that the licensee failed to perform any evacuation drills in the second half of the year 2022 and no drills performed in 2023 to date. The minimum required frequency of two evacuation drills for employees is twice per year per shift with at least one evacuation every other month. The LALD-C confirmed with the findings and commented that they did have a fire drill scheduled for the next day.</p> <p>On February 14, 2023, at approximately 2:00 p.m., during the exit interview, the licensed assisted living director (LALD)-C and the LALD-G acknowledged the above findings.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 810		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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0 970	<p>Continued From page 15</p> <p>liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 of the residents).</p> <p>The findings include:</p> <p>On February 13, 2023, at approximately 10:00 a.m., licensed assisted living director (LALD)-C provided the licensee's blank Assisted Living Contract: Terms &amp; Conditions and indicated the document was the licensee's assisted living contract used for all residents.</p> <p>The assisted living contract read in section 25. Liability, "Provider is not liable to Resident ... for any injury, death or property damage occurring in the Suite or on Provider's premises unless such</p>	0 970		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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0 970	<p>Continued From page 16</p> <p>injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents."</p> <p>On February 15, 2023, at 12:00 p.m., LALD-C indicated the licensee's assisted living contract included language waiving licensee's liability for health, safety, and personal property of the residents. LALD-C indicated the licensee was not aware of the prohibition for waivers of liability.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 970		
01290 SS=C	<p>144G.60 Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01290	<p>Continued From page 17</p> <p>review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living with dementia care license for two of two employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A was hired August 11, 2022.</p> <p>LPN-A's record included Department of Human Services Background Study Clearance letter dated December 27, 2022, associated with licensee's expired Health Facility Identification (HFID) license number 27917.</p> <p>ULP-B was hired on April 25, 2022.</p> <p>ULP-B's record included Department of Human Services Background Study Clearance letter dated May 6, 2022, associated with licensee's expired Health Facility Identification (HFID) license number 27917.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B performed resident cares which included medication administration and activities of daily living.</p> <p>LPN-A and ULP-B's employee records lacked</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01290	<p>Continued From page 18</p> <p>evidence of current, cleared BGS affiliated with the licensee's current assisted living with dementia care license #32276, effective August 1, 2021.</p> <p>On February 15, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C indicated the BGS for many of the licensee's employees were under the former comprehensive license versus the new assisted living license. LALD-C indicated the BGS were conducted at the corporate office associated with the expired HFID and not under the current HFID for the active assisted living with dementia care license.</p> <p>The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would complete pre-employment BGS required for all employees, but failed to indicate the BGS would be completed under the licensee's current HFID..</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
01440 SS=F	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(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</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01440	<p>Continued From page 19</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed by a registered nurse within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B was hired on April 25, 2022.</p> <p>ULP-B's Skill Competency Medication Administration - Routes dated May 27, 2022, indicated ULP-B was trained and found</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01440	<p>Continued From page 20</p> <p>competent by the signature of a licensed practical nurse (LPN).</p> <p>ULP-B's training record lacked documentation a registered nurse (RN) trained, delegated, and then supervised within 30 calendar days the delegated task of medication administration.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B performed resident cares which included the delegated task of medication administration.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-D indicated ULP-B was trained by an LPN and not an RN as required per statute. DON-D stated a 30-day RN supervision was not documented in ULP-B's record and would need to be completed. LALD-C indicated the licensee had a period of time in which an LPN was providing training and supervision of staff while RN staffing was short.</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated a RN would complete direct supervision within 30 days of the task being delegated to a ULP.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01440		
01470 SS=F	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01470	<p>Continued From page 21</p> <p>(1) an overview of this chapter;</p> <p>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</p> <p>(3) handling of emergencies and use of emergency services;</p> <p>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</p> <p>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01470	<p>Continued From page 22</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A and ULP-B were hired August 11, 2022, and April 25, 2022, respectively.</p> <p>LPN-A and ULP-B's records included My Transcript documents identified by licensed assisted living director (LALD)-C as the documents all training both LPN-A and ULP-B</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01470	<p>Continued From page 23</p> <p>had completed.</p> <p>LPN-A and ULP-B's training transcripts lacked documentation of the following:</p> <ul style="list-style-type: none"> <li>- an overview of this chapter;</li> <li>- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</li> <li>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</li> <li>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and</li> <li>-consumer advocacy services; and review of types of assisted living services the employee will provide and provider's scope of license.</li> </ul> <p>On February 15, 2023, at 12:00 p.m., LALD-C indicated the licensee had failed to assign the required training within the licensee's selected training program.</p> <p>The licensee's policy 5.01, Orientation of Staff and Supervisors &amp; Content policy dated August 1, 2021, indicated all staff would have the required training completed prior to providing services to residents.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01620	<p>Continued From page 24</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day reassessment and ongoing resident monitoring and reassessment not to exceed 90 days from the previous assessment for two of three residents (R2, R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a</p>	01620		

Minnesota Department of Health

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01620	<p>Continued From page 25</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted on April 4, 2019.</p> <p>R2's record contained an Assessment As Of Date dated November 11, 2022, indicated by licensed assisted living director (LALD)-C as R2's most recent assessment. R2's record contained no further assessments.</p> <p>R4 was admitted on January 26, 2023.</p> <p>R4's record contained an Assessment As Of Date dated January 26, 2023, was identified by LALD-C as R4's most recent and admission assessment. R4's record contained no further assessments.</p> <p>On February 15, 2023, at approximately 12:00 p.m., director of nursing (DON)-D indicated the licensee was aware some resident assessments were not completed within the required timeframes. DON-D indicated the licensee was aware of all required assessment time frames.</p> <p>The licensee's 6.01 Assessments, Reviews &amp; Monitoring policy dated August 1, 2021, indicated the RN conduct a nursing assessment of physical and cognitive needs and reassessment conducted no more than 14 calendar days after initiation of services and ongoing cannot exceed 90 calendar days from the last date of the assessment.</p> <p>No further information provided.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01620	Continued From page 26	01620		
01640 SS=E	<p><b>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</b></p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan or revisions included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for two of three residents (R2, R3).</p>	01640		

Minnesota Department of Health

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01640	<p>Continued From page 27</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>R2 was admitted on March 4, 2019.</p> <p>R2's signed Resident Service Plan dated March 4, 2019, included fourteen services to be provided.</p> <p>R2's unsigned current Resident Service Plan dated February 14, 2023, included twenty-seven services to be provided.</p> <p>R3 admitted on March 10, 2016.</p> <p>R3's signed Resident Service Plan dated January 1, 2016, included twelve services to be provided.</p> <p>R3's unsigned current Resident Service Plan dated February 14, 2023, included twenty-four services to be provided.</p> <p>R2 and R3's unsigned Resident Service Plans provided by licensed assisted living director (LALD)-C and indicated as R2 and R3's current service plans, lacked a signature or authentication by the licensee or by the resident or resident's representative.</p>	01640		

Minnesota Department of Health

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01640	<p>Continued From page 28</p> <p>On February 15, 2023, at approximately 12:00 p.m., LALD-C indicated R2 and R3's service plan lacked authentication by the licensee or by the resident or resident's representative. LALD-C stated the service plan should have included the required authentication and maintained in the resident's record.</p> <p>The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated all service plans and revisions would include a signature or authentication by the licensee or by the resident or resident's representative.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01700 SS=F	<p><b>144G.71 Subd. 2 Provision of medication management services</b></p> <p>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions</p>	01700		

Minnesota Department of Health

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01700	<p>Continued From page 29</p> <p>needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R2, R3, R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p> <p>The findings include:</p> <p>On February 13, 2023, during entrance conference, director of nursing (DON)-D stated resident assessments are filled in by a licensed practical nurse (LPN) and DON-D reviewed and signed assessments as completed.</p> <p>R2, R3, and R4's Assessment As of Date identified by DON-D as R2, R3, and R4's current assessments and included all required content for</p>	01700		

Minnesota Department of Health

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01700	<p>Continued From page 30</p> <p>each resident's medication management record were all digitally signed by DON-D as completed. R2, R3, and R4's assessment all indicated each resident received medication management as a service and included all required content for a medication management record.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and DON-D stated the licensee's current practice for all assessments was to have the LPN complete the assessment form in the licensee's electronic health record (EHR), and then the RN would log into the EHR to review the LPN's assessment form information and then sign off the assessment as completed. LALD-C and DON-D indicated the licensee thought an LPN could gather all the assessment data and the RN reviewing it would meet the requirement for the assessment, however DON-D stated this meant the RN was not completing the assessment and the medication management record face to face as required.</p> <p>The licensee's 7.01 Medication Management - Assessment, Monitoring &amp; Reassessment policy dated August 1, 2021, originally indicated under "Procedure," assessments for medication management would be conducted face-to-face, the licensee had highlighted and crossed out the words, "face-to-face."</p> <p>The licensee's 6.01 Assessments, Reviews &amp; Monitoring policy dated August 1, 2021, indicated assessments would be conducted in person.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01750 SS=I	<p><b>144G.71 Subd. 7 Delegation of medication administration</b></p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <ul style="list-style-type: none"> <li>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</li> <li>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and</li> <li>(3) communicated with the unlicensed personnel about the individual needs of the resident.</li> </ul> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) completed competency evaluations for the delegated task of medication administration for two of two unlicensed personnel ((ULP)-B and ULP-F).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-B was hired April 5, 2022.</p> <p>ULP-B's Skill Competency dated May 27, 2022,</p>	01750		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01750	<p>Continued From page 32</p> <p>indicated ULP-B was competent for all medication routes the licensee delegated to ULPs and signed by a licensed practical nurse (LPN).</p> <p>ULP-F was hired April 18, 2016.</p> <p>ULP-F's Skill Competency dated July 2, 2020, indicated ULP-F was competent for all medication routes the licensee delegated to ULPs by a LPN.</p> <p>On February 14, 2023, at approximately 7:00 a.m., the surveyor observed ULP-B and ULP-F provide the delegated task of medication administration to multiple residents during the licensee's morning medication administration time including oral medications and eye drops.</p> <p>On February 14, 2023, at approximately 1:15 p.m., licensed assisted living director (LALD)-C stated the licensee previously had a LPN provide the competency training to ULPs. LALD-C stated the licensee recently changed to having only a RN, as required by statute, provide competency to ULPs, but had not re-trained those who received competency training from a LPN.</p> <p>The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations of ULPs would be conducted by a RN.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On February 15, 2023, the immediacy of correction order 1750 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and level of I.</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01790 SS=F	<p><b>144G.71 Subd. 10 Medication management for residents who will</b></p> <p>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;</p> <p>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and</p> <p>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.</p> <p>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:</p> <p>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and</p> <p>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:</p> <p>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;</p> <p>(ii) how the container or containers must be labeled;</p> <p>(iii) written information about the medications to be provided;</p> <p>(iv) how the unlicensed staff must document in the resident's record that medications have been</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01790	<p>Continued From page 34</p> <p>provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;</p> <p>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;</p> <p>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and</p> <p>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide training to unlicensed personnel ((ULP)-B) for giving accurate and current medications for those residents who received medication management services during unplanned times away from home. This has the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01790	<p>Continued From page 35</p> <p>The findings include:</p> <p>ULP-B was hired on April 25, 2022.</p> <p>On February 14, 2023, at approximately 6:50 a.m., ULP-B provided medication administration to R2 and R3.</p> <p>ULP-B's record lacked documentation they were trained, delegated, and supervised on the licensee's policy and procedure for management of medication for residents who may have unplanned times away from home.</p> <p>On February 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C and director of nursing (DON)-D stated the licensee does not train any ULPs for handling unplanned times away. DON-D stated ULPs were to contact the on-call nurse for any unplanned times away to receive direction on medication preparation, so no ULP had received training or supervision for the delegated task.</p> <p>The licensee's 7.10 Medication Management - Planned &amp; Unplanned Time Away policy dated August 1, 2021, indicated if licensee was providing medication management, ULPs would be trained and supervised for management for unplanned times away from home.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01790		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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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
01940	<p>Continued From page 36</p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:</p> <ul style="list-style-type: none"> <li>(1) a statement of the type of services that will be provided;</li> <li>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</li> <li>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</li> <li>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li> <li>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management record to include all required content for one of two residents (R5) who had a treatment.</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01940	<p>Continued From page 37</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's Assessment As Of Date dated December 28, 2022, read under section Eating -Dietary, "Recommended idea (select from list) Regular, Regular - Nectar Thick. Complies with diet - specify: Nectar thick liquids."</p> <p>R5's physician's order signed January 9, 2023, by R5's provider read, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>On February 14, 2023, at approximately 6:50 a.m., observed a white with yellow top container labeled, "Thick-It," name brand with R5's name printed on the cover sitting on the counter in R5's secured unit kitchen counter. Unlicensed personnel (ULP)-F indicated container was used per the manufacturer's instructions for all of R5's liquids.</p> <p>R5's record lacked a treatment plan with all required content for the provider ordered thickener.</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRELUDE HOMES &amp; SERVICES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4650 WHITE BEAR PARKWAY WHITE BEAR LAKE, MN 55110</b>
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01940	<p>Continued From page 38</p> <p>On February 14, 2023, at approximately 1:45 p.m., licensed assisted living director (LALD)-C indicated licensee was not aware provider ordered thickener required a treatment plan. LALD-C stated a treatment plan was not developed or implemented for R5 related to their thickener.</p> <p>The licensee's 7.05 Treatment &amp; Therapy Management Plan policy dated August 1, 2021, indicated a treatment plan with all required content would be developed and implemented for all ordered or prescribed treatments and therapy services.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
01950 SS=D	<p>144G.72 Subd. 4 Administration of treatments and therapy</p> <p>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:</p> <p>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the</p>	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01950	<p>Continued From page 39</p> <p>ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</p> <p>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) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5) who had an ordered treatment.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 was admitted on December 27, 2022.</p> <p>R5's diagnoses included Alzheimer's Dementia, hypothyroidism, and dysphagia (swallowing difficulties).</p> <p>R5's Assessment As Of Date dated December 28, 2022, read under section Eating -Dietary, "Recommended idea (select from list) Regular, Regular - Nectar Thick. Complies with diet - specify: Nectar thick liquids."</p> <p>R5's physician's order signed January 9, 2023, by</p>	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01950	<p>Continued From page 40</p> <p>R5's provider read, "Order for thick-it original (thickener) Dx: R13.10 Dysphagia."</p> <p>On February 14, 2023, at approximately 6:50 a.m., observed a white with yellow top container labeled, "Thick-It," name brand with R5's name printed on the cover sitting on the counter in R5's secured unit kitchen counter. Unlicensed personnel (ULP)-F indicated container was used per the manufacturer's instructions for all of R5's liquids when R5 was provided liquids.</p> <p>R5's record lacked a treatment plan the RN provided with:</p> <ul style="list-style-type: none"> <li>- instruction to the unlicensed personnel in the proper methods with respect to each resident and documented the unlicensed personnel has demonstrated the ability to competently follow the procedures;</li> <li>- specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</li> <li>- communicated with the unlicensed personnel about the individual needs of the resident.</li> </ul> <p>On February 14, 2023, at approximately 1:45 p.m., licensed assisted living director (LALD)-C indicated licensee was not aware provider ordered thickener required a treatment plan. LALD-C stated a treatment plan was not developed or implemented for R5 related to their thickener. Director of nursing (DON)-D stated a treatment had not been developed and the ULPs had not been provided specific instruction other than the manufacturer's instruction on the side of the container.</p> <p>The licensee's 7.05 Treatment &amp; Therapy Management Plan policy dated August 1, 2021, indicated a treatment plan with all required</p>	01950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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01950	Continued From page 41  content would be developed and implemented for all ordered or prescribed treatments and therapy services.  No further information provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment  An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.  This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	02040		

Minnesota Department of Health

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02040	<p>Continued From page 42</p> <p>client'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 clients).</p> <p>The findings include:</p> <p>On February 14, 2023, at approximately 2:00 p.m., a documentation review and interview were performed with the licensed assisted living director (LALD)-G and LALD-C on the hazard vulnerability assessment and mitigation plan for the memory care physical environment of the property. Based on the document review and interview, the licensee failed to provide a site-specific hazard vulnerability (safety risk) assessment and mitigation plan to protect the memory care residents from harm. During the interview, the LALD-G and the LALD-C confirmed that they had not developed the plan but were currently working on developing it. This finding was evident as there was no site-specific plan documentation provided for review.</p> <p>On February 14, 2023, at approximately 2:15 p.m., survey staff discussed the observations and findings and explained to the LALD-C and the LALD-G that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2023</b>
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02310	Continued From page 43	02310		
02310 SS=G	<p><b>144G.91 Subd. 4 (a) Appropriate care and services</b></p> <p>(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.</p> <p>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 standards, medical or nursing standards for one of one resident (R2) who utilized bed rails.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2 admitted on March 4, 2019.</p> <p>R2's Assessment As Of Date dated November 14, 2022, indicated R2 used an electric bed with a partial side rail attached to bed.</p> <p>R2's record lacked the following information:</p> <ul style="list-style-type: none"> <li>- the side rails use/need assessment;</li> <li>- the purpose and intention of the side rails;</li> <li>- documentation of the risks vs. benefits</li> </ul>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 44</p> <p>discussion with the resident or responsible party;</p> <ul style="list-style-type: none"> <li>- measurements completed and documented;</li> <li>and</li> <li>- the side rails were Food and Drug Administration (FDA) compliant.</li> </ul> <p>On February 14, 2023, at approximately 7:20 a.m., the surveyor observed R2's bed with hospital style side rail in place.</p> <p>On February 14, 2023, at approximately 12:00 p.m., licensed assistant living director (LALD)-C and director of nursing (DON)-D stated if a side rail assessment were to be completed, it would be in the resident's assessment.</p> <p>The licensee's 6.28 Side Rails policy dated August 1, 2021, indicated all identified assessment areas would be completed prior to side rail use for the safety of the resident.</p> <p>The FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated the above lacking areas of licensee's assessment would be required to be completed for the safety of the resident that utilized side rails.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On February 15, 2023, the immediacy of correction order 2310 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and level of G.</p>	02310		



Minnesota Department of Health  
Food Pools & Lodging Services  
P.O. Box 64975  
St Paul, MN 55164-0975  
651 201 4500

Type: Full  
Date: 02/13/23  
Time: 14:40:16  
Report: 8058231042

## Food and Beverage Establishment Inspection Report

Page 1

### Location:

Prelude Homes & Services Llc  
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 #: 6513583655  
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.

### 3-500B Microbial Control: hot and cold holding

#### 3-501.16A2

**\*\* Priority 1 \*\***

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS IN WALK IN COOLER RANGE FROM 41 TO 47 DF - INSTRUCTED NOT TO KEEP TEMPERATURE CONTROL FOR SAFETY ITEMS IN WALK IN UNTIL REPAIRED (MOVE TO FUNCTIONAL COOLER/FREEZER)

Comply By: 02/13/23

### 3-500C Microbial Control: date marking

#### 3-501.17A

**\*\* Priority 2 \*\***

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

DATE MARKING IS NOT BEING COMPLETED IN THE THREE COOLERS IN THE LOCKED WINGS

Comply By: 02/13/23

### 4-500 Equipment Maintenance and Operation

#### 4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

WALK IN COOLER UNABLE TO MAINTAIN ITEMS AT 41 DF OR LOWER - REPAIR OR REPLACE COOLER

Comply By: 02/23/23

Type: Full  
Date: 02/13/23  
Time: 14:40:16  
Report: 8058231042  
Prelude Homes & Services Llc

# Food and Beverage Establishment Inspection Report

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## Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit  
Location: SANI SINK  
Violation Issued: No

---

## Food and Equipment Temperatures

Process/Item: PIZZA  
Temperature: 188 Degrees Fahrenheit - Location: COOKED  
Violation Issued: No

Process/Item: LETTUCE  
Temperature: 44 Degrees Fahrenheit - Location: WALK IN  
Violation Issued: Yes

Process/Item: CUCUMBER WHOLE  
Temperature: 47 Degrees Fahrenheit - Location: WALK IN  
Violation Issued: Yes

Process/Item: RAW EGG  
Temperature: 43 Degrees Fahrenheit - Location: WALK IN  
Violation Issued: No

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

Process/Item: LETTUCE  
Temperature: 41 Degrees Fahrenheit - Location: COOLER 1  
Violation Issued: No

Process/Item: BREAD  
Temperature: 41 Degrees Fahrenheit - Location: COOLER 2  
Violation Issued: No

Process/Item: SAUSAGE  
Temperature: 41 Degrees Fahrenheit - Location: COOLER 3  
Violation Issued: No

---

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

COMMERCIAL KITCHEN SPACE

HRD INSPECTOR BRANDON MUELLER

ITEMS IN WALK IN COOLER PREPPED OR HELD LONGER THAT A DAY THAT ARE TEMPERATURE CONTROLLED FOR SAFETY MOVED TO FREEZER/COOLERS ON SITE

COOLERS IN THE LOCKED WINGS SHOULD BE MAINTAINED BY THE KITCHEN STAFF

Type: Full  
Date: 02/13/23  
Time: 14:40:16  
Report: 8058231042  
Prelude Homes & Services Llc

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058231042 of 02/13/23.

Certified Food Protection Manager: HEATHER ALLEN

Certification Number: 69962 Expires: 08/16/25

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

Signed: \_\_\_\_\_

Establishment Representative

Signed:  \_\_\_\_\_

Inspector Number 8058  
Sanitarian 3  
MDH Metro Office  
651 201 4500  
health.foodlodging@state.mn.us