Electronically Delivered

April 12, 2023

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

RE: Project Number(s) SL34601015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 21, 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 . . ."

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 evaluation of your facility**.

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

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,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34601015 On March 20, 2023 through March 21, 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 49 active residents; of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 1 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated March 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 2 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing, and training for one of three employees (unlicensed personnel (ULP)-D). 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). Findings include: The facility TB risk assessment was completed August 26, 2022, and indicated the facility was at a low risk for TB transmission. ULP-D was hired December 10, 2018, and provided direct care services to the residents of	0 660		

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0 660	Continued From page 3 the facility. ULP-D's employee record included a TB history and symptom screening form completed upon hire, and documentation of a tuberculin skin test (TST) completed January 24, 2018, greater than 90 days before hire. The TB screening form indicated a TST was completed upon hire on December 15, 2018. The millimeters (mm) of induration was documented as "<5" (less than 5 mm), which would indicate a negative test, but was identified on the form as a positive result with the notation, "Requires Xray". ULP-D's record lacked documentation of a second step TST or a follow-up chest x-ray to rule out the presence of TB. On March 20, 2023, at 10:50 a.m., licensed assisted living director (LALD)-A stated director of clinical services (DCS)-B was in charge of the TB infection control program and training of staff. On March 20, 2023, at 3:52 p.m., LALD-A stated she thought ULP-D had a chest x-ray, and would contact DCS-B to verify what they had on file for ULP-D. On March 21, 2023, at 10:10 a.m., LALD-A stated no additional TB screening or training documentation was available for ULP-D. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated staff would be educated regarding TB at the time of hire. The policy further indicated staff, "will be screened and tested for tuberculosis prior to the staff being exposed to clients."	0 660		

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

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0 680	Continued From page 5 the potential to affect all fifty two (52) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 21, 2023, at 11:21 a.m., during review of the licensee's emergency preparedness plan, it was noted that the licensee's emergency preparedness plan lacked the following required content: -Emergency preparedness (EP) plan updated annually, must document date of review and any updates made based on the review -EP policies and procedures must address: use of volunteers, including the process/role for integration -Develop a written communication plan -Communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers and alternative methods for communication. -Develop a process for EP cooperation with state and local EP officials/organizations. -EP training and testing program; -EP training program for staff (including documentation of training provided); -Annual EP testing requirements.	0 680		

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0 680	Continued From page 6 On March 21, 2023, at 12:05 p.m., licensed assisted living director (LALD)-A confirmed the licensee's emergency preparedness plan lacked required content referenced above due to facilities director being only six months in the position. LALD-A stated the company had recently purchased the Care Providers template for emergency preparedness. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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		

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0 810	Continued From page 7 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to have fire safety and evacuation plans with the required elements and failed to conduct the required drills. These deficient practices had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident 's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 22, 2023, at approximately 12:30 p.m., the following was noted through interview and record review with Licensed Assisted Living Director (LALD)-A, Culinary Director (CD)-H, and Facilities Director (FD)-G.	0 810		

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0 810	Continued From page 8 1. Review of the available documentation indicated the licensee failed to describe the employees' actions to be taken in the event of a fire or similar emergency. 2. Review of the available documentation indicated the licensee failed to provide fire safety and evacuation plans that were always readily available within the facility. 3. Review of the available documentation indicated that evacuation drills were not performed twice per year per shift with at least one drill conducted every other month. All deficiencies were verified by LALD-A, CD-H, and FD-G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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0 950	Continued From page 9 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing by not requiring the contract section to be filled out, for three of four residents (R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted February 7, 2022, and received services including bathing, linen changes, dressing, grooming, housekeeping, laundry, meal assistance, nail care, oral care, vital signs, safety checks, assistance with medication management and toileting.	0 950		

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0 950	Continued From page 10 R4 was admitted November 4, 2019, and received services including assistance with medication management, personal hygiene, grooming, dressing, housekeeping, and laundry. R5 was admitted September 27, 2022, and received services including assistance with personal hygiene, grooming, dressing, housekeeping, and laundry. R2, R4, and R5's resident contracts, dated February 1, 2022, August 2, 2021, and September 23, 2022, respectively, lacked the acknowledgment for the residents to initial indicating if they declined to name a designated representative, or choose to name a representative. On March 21, 2023, at 12:05 p.m., licensed assisted living director (LALD)-A stated licensee created a new contract after a sister site survey to include the required designation of representative verbatim, but they had not sent it out for updated signatures. LALD-A stated her plan was to send out a mass email the next week to all residents and create a tracking system to get back all the contract signatures to meet the requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 11	0 970		

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.

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 for four of four residents (R2, R3, R4, R5).

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 findings include:

R2 was admitted February 7, 2022, and received services including assistance with bathing, ADLs, housekeeping, laundry, medication management, safety checks, and toileting. .

R3 was admitted August 31, 2022, and received services including assistance with bathing, ADLs, housekeeping, laundry, medication management, continuous positive airway pressure (CPAP), blood glucose monitoring, vital signs, and toileting.

R4 was admitted November 4, 2019, and

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0 970	Continued From page 12 received services including assistance with medication management, personal hygiene, grooming, dressing, housekeeping, and laundry. R5 was admitted September 27, 2022, and received services including assistance with personal hygiene, grooming, dressing, housekeeping, and laundry. R2, R3, R4, and R5's Assisted Living Contract signed February 1, 2022, August 31, 2022, August 2, 2021, and September 23, 2022, respectively, included the following sections, indicating a waiver of liability: Section 18. Personal Property, which read, "Resident agrees that provider is not responsible for any loss or damage to residents' personal property due to any reason or cause, including theft, other than provider's own negligence. Resident further agrees that provider is not responsible for damage to residents' personal property due to fire, water, tornado or other acts of nature and events beyond providers control. Resident is strongly encouraged to obtain renters insurance." Section 23. Indemnification, which read, "As an occupant of the community, resident assumes the risk for residents own safety and for the safety of resident's guests and agents. Resident will indemnify and hold harmless provider, its employees, officers, managers. owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of resident or residents' guests or agents."	0 970		

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	34601	A. BUILDING: _____ B. WING _____	03/21/2023

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0 970	Continued From page 13 Section 24. Insurance, which read, "Provider will maintain appropriate levels and types of insurance covering the building and its contents. Because provider does not maintain insurance covering the contents of residents' suites is [sic] strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the suite, as well as any injury to resident or resident's guests occurring within the suite ("renter's insurance"). Resident acknowledges and understands that the lack of such insurance coverage may result in personal loss to and/or liability of resident." Section 25. Liability, which read, "Provider is not liable to Resident or resident's guests 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 result of provider's own negligent acts or omissions, or those of its employees, officers, mangers, owners or agents. Provider is also not liable for any injury, death or damage occurring as a result of resident's receipt of health related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the suite or on provider's premises" On March 21, 2023, at 12:05 p.m., licensed assisted living director (LALD)-A stated the licensee understood the contract included language waiving licensee's liability. LALD-A stated licensee updated the contract to reflect the acceptable statute language but has not sent it out to residents and POAs for updated signatures but will be doing this next week with a mass email	0 970		

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0 970	Continued From page 14 out with a deadline to return. LALD-A stated licensee will have a tracking system to make sure they get all the contracts updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	01380		

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01380	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired December 10, 2018, and began providing direct care assisted living services August 1, 2021. ULP-D's employee record lacked documentation ULP-D received the following training and competency: -medication, exercise, and treatment reminders; -understanding appropriate boundaries between staff and clients and the client's family; and -recognizing physical, emotional, cognitive, and developmental needs of the client. On March 21, 2023, director of clinical services (DCS)-B stated both she and licensed assisted living director (LALD)-A were responsible for employee orientation and training. DCS-B stated staff received most of their training and orientation through online courses. DCS-B stated they had updated the process for documenting training for new employees. The licensee's Competency Training Evaluations, dated March 9, 2023, indicated training and competency evaluations for all ULPs would include medication, exercise, and treatment reminders, understanding appropriate boundaries between staff and residents and the resident's family, and recognizing physical, emotional,	01380		

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01380	Continued From page 16 cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 17 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of three employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01470		

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01470	Continued From page 18 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired December 10, 2018, and began providing direct care assisted living services August 1, 2021. ULP-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -An overview of the appropriate Assisted Living statutes 144 G and rules; -Review of providers policies and procedures; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services; and -Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-E ULP-E was hired March 8, 2021, and began providing direct care assisted living services August 1, 2021. ULP-E's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services:	01470		

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01470	Continued From page 19 -An overview of the appropriate Assisted Living statutes 144 G and rules; -Review of providers policies and procedures; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -Consumer advocacy services. On March 21, 2023, director of clinical services (DCS)-B stated both she and licensed assisted living director (LALD)-A were responsible for employee orientation. DCS-B stated staff received most of their training and orientation through online courses. DCS-B stated they had updated the process for documenting orientation for new employees and annual training for existing employees. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, "All staff of [licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." The policy further indicated, "The orientation must contain the following topics: · An overview of the appropriate Assisted Living statutes and rules · An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person · Handling of emergencies and use of emergency services · Compliance with and reporting of the	01470		

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01470	Continued From page 20 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) · The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights · Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person · Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints · 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 · A review of the types of assisted living services the employee will be providing and the facility's category of licensure". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01540		

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01540	Continued From page 21 employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of three employees, unlicensed personnel (ULP)-D. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2021. ULP-D was hired December 10, 2018, and began providing assisted living services August 1, 2021. ULP-D's training and orientation records lacked documentation of 8 hours of dementia care training completed within 80 working hours to	01540		

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01540	Continued From page 22 include the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On March 20, 2023, at 1:17 p.m., licensed assisted living director (LALD)-A did not provide further dementia care training documentation for ULP-D. LALD-A stated the initial dementia care training documentation is in place for newer employees, but agreed initial training for more seasoned employees such as ULP-D was not as clearly documented. On March 21, 2023, director of clinical services (DCS)-B stated staff received most of their education, including dementia care training, through online courses. DCS-B stated they were in the process of ensuring all employees were up to date with training. The licensee's Dementia Training policy, dated August 1, 2021, indicated direct care staff would complete eight (8) hours of initial training within 80 hours of the employees start date. The policy further indicated, "Required dementia training topics include: · An explanation of Alzheimer's disease and other dementias · Assistance with activities of daily living · Problem solving with challenging behaviors · Communication skills · Person centered planning and service delivery" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01540		

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01540	Continued From page 23 (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure reassessment and monitoring did not exceed 90 days from the last date of the assessment for one of seven residents (R4) with records reviewed. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 24 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to memory care services at the assisted living facility on November 4, 2019. R4's diagnoses included Alzheimer's dementia. R4's recent 90 day assessments were dated October 20, 2022 and February 22, 2023. These assessments indicated R4 required assistance to include medication management, personal hygiene, grooming, dressing, housekeeping, and laundry. On March 21, 2023, at approximately 10:30 a.m. RN-B confirmed R4's reassessment had not been completed within 90 days, as required. The licensee's Assessment, Reviews, and Monitoring policy, dated March 23, 2023, directed resident monitoring and review not exceed 90 days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 25 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerators. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 21, 2023, at 11:07 a.m., the medication refrigerator in the "Hope" cottage of the north building was observed to lack a thermometer and temperature log to document the refrigerator was maintained within the manufacturer recommended range for storage of refrigerated medications. The refrigerator contained four unopened bottles of latanoprost 0.005% opthalmic (an eye drop used to treat glaucoma). Manufacturer directions observed on the box for latanoprost indicated, "Store unopened bottle under refrigeration at 2° to 8° C [Celsius] (36° to 46° F [Fahrenheit]). On March 21, 2023, at 11:11 a.m., director of	01880		

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01880	Continued From page 26 clinical services (DCS)-B stated staff had not been instructed to monitor refrigerator temperatures. DCS-B further stated she had not yet begun to update the process of monitoring temperatures in the medication refrigerator. The licensee's Medication Storage policy, dated August 1, 2021, indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34601	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRELUDE HOMES AND SERVICES	10018 RALEIGH ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 27 for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were held on March 22, 2023, at approximately 12:30 p.m. with the Licensed Assisted Living Director (LALD)-A, Culinary Director (CD)-H, and Facilities Director (FD)-G. Review of the available documentation indicated that the licensee did not provide a hazard vulnerability assessment that was performed on and around the property and subsequently, mitigation factors were not provided for hazards associated with the physical environment. This deficient condition was verified by (LALD)-A, (CD)-H, and (FD)-G. TIME PERIOD FOR CORRECTION: 21 DAYS	02040		

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

Type: Full
Date: *03/22/23*
Time: 11:09:12
Report: 1023231053

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0039225
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515016516
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

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

MEASURED CHLORINE SANITIZER OF DISH MACHINE IN AUXILIARY SERVICE AREA TOO LOW. SERVICE MACHINE AND VERIFY EFFECTIVE SANITIZER CONCENTRATION.

Comply By: 03/22/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

OPERATOR STATED NO CHLORINE TEST KITS AVAILABLE BUT CHLORINE IN USE FOR DISH MACHINES. OBTAIN AND USE THESE STRIPS TO ENSURE EFFECTIVE SANITIZATION.

Comply By: 03/22/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC TYPE REFRIGERATOR IN USE FOR COMMERCIAL FOOD SERVICE IN AUXILIARY SERVICE AREA. REPLACE WITH COMMERCIAL GRADE EQUIPMENT.

Comply By: 03/22/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

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

Comply By: 03/22/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET #1
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET #2
Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit
Location: DISH MACHINE #1
Violation Issued: No

Chlorine: = 10PPM at Degrees Fahrenheit
Location: DISH MACHINE #2
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cooking/ROAST
Temperature: 190 Degrees Fahrenheit - Location: FROM OVEN
Violation Issued: No

Process/Item: Cooling/CASSEROLE
Temperature: 90 Degrees Fahrenheit - Location: IN ICE BATH @ 1 HOUR
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/FRUIT
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER AUXILIARY
Violation Issued: No

Type: Full
Date: *03/22/23*
Time: 11:09:12
Report: 1023231053
Prelude Homes And Services

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD. THIS FACILITY CONSISTS OF TWO FULL SERVICE KITCHEN AREAS WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

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 1023231053 of 03/22/23.

Certified Food Protection Manager: HEATHER ALLEN

Certification Number: 69962 Expires: 08/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
HEATHER ALLEN
PERSON IN CHARGE

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