Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346019463M
Compliance #: HL346013721C

Date Concluded: April 21, 2026

Name, Address, and County of Licensee Investigated:
Prelude Homes and Services
10020 Raleigh Road
Woodbury, MN 55129
Washington County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Inconclusive

Nature of Investigation: The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s): The alleged perpetrator (AP) abused the resident when the AP made a gestured threat to "body slam" the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. Although the AP, an unlicensed caregiver, made inappropriate comments and gestures during a conversation with a co-worker, it is unclear if the AP realized the resident was present.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and history of a traumatic brain injury causing memory loss. The resident's service plan included assistance with medication management, behavior monitoring and safety checks every two hours. The resident's assessment indicated he was able to walk independently, but had impaired decision making and was exit seeking at times.

A facility document indicated while managers were investigating an altercation between the resident and unlicensed caregiver #1, they reviewed video footage and saw the AP making gestured aggression in the direction of the resident.

The video view shows the kitchen area and half of the dining area, the video does not show the area behind the dining area or the hallway on the side of the kitchen and dining area which is a large area.

The video began with unlicensed caregiver #1 and the AP discussing the incident when the AP stated to unlicensed caregiver #1, "you are better than me, I would have picked him up like this and boom, right on the ground" while making a gesture of putting her arms over her head and stepped forward moving her arms down twice. The resident could not be seen on the video, however when a voice is heard on the video, the AP immediately stopped the behavior and walked back towards unlicensed caregiver #1.

During an interview, the manager stated the facility video was reviewed after the facility received a report regarding the resident's aggression towards unlicensed caregiver #1. The video later showed the AP making inappropriate comments and gestures in regard to the incident. The manager stated she could hear the resident's voice in the video but the resident could not be seen on the video. The manager suspended the AP and an investigation was completed. The manager stated the resident was interviewed quickly that same day and could not recall either incident that occurred.

During an interview, the AP stated she realized her statements and gestures were wrong, but both were made during a conversation with unlicensed caregiver #1 and were not intended to be heard by the resident. The AP stated she did not realize the resident was in the immediate area, but he could have overheard their conversation.

During an interview, unlicensed caregiver #1 stated she was in pain and could not remember what the AP said or any gestures made.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, attempted to interview but unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility suspended the AP while investigating the incident. At the time of the investigation, the AP was no longer employed at the facility.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 _____	C 03/10/2026

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 On March 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL346013721C/#HL346019463M. No correction orders are issued.	0 000		