Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322766064M
Compliance #: HL322761521C

Date Concluded: June 27, 2023

Name, Address, and County of Licensee Investigated:
Prelude Homes
4650 White Bear Parkway
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, individual responsibility

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 perpetrators (AP1, AP2, and AP3) neglected a resident when the resident had a fall resulting in fractures in her right leg and foot and the APs did not report the resident's changes of condition to the nurse.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP1, AP2, and AP3 were responsible for the maltreatment. After the resident had an unwitnessed fall; the resident complained of pain, was unable to bare weight on her leg, and AP1 and AP2 were observed in the resident's room discussing the resident's right leg appearing abnormal. AP1 and AP2 did not notify the nurse of the resident pain and/ or change of condition following the fall. AP3 worked the overnight shift which was approximately 2 hours following the residents fall. AP3 failed to check on the resident and/or complete any of the residents' cares. When the morning staff attempted to assist the resident with cares the resident was crying in pain. The resident was sent to the hospital and diagnosed with tibia and fibula (lower leg bones) fractures in her right

leg, as well as second through fourth metatarsal (foot bones) fractures to her right foot. The resident was unable to call for staff assistance, and staff did not interact with the resident or provide cares for the resident for approximately 11 hours following the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of hospital records, medical records, staff charting, staff training and personnel files, camera footage, and pictures. Also, the investigator observed staff care of residents.

The resident resided in an assisted living memory care unit with diagnoses including dementia with behavioral disturbances. The resident's service plan included assistance with bathing, dressing, grooming, toileting, meals, laundry, housekeeping, behavior monitoring, and medication management. The resident's assessment indicated the resident had functional and cognitive impairments that put her at an increased risk for falls.

The assessment indicated there was no call system in the resident's room due to the resident's cognition and staff were directed to provide safety checks every two hours to ensure the resident's needs were met. Staff were also directed to assist the resident with toileting two times during the overnight shift (11:00 p.m.- 7:00 a.m.).

A facility investigation indicated the facility taped camera footage of the incident was reviewed and the resident was observed walking around the memory care unit and fell just before 9:00 p.m. The resident landed on her bottom with her right leg pinned beneath her. The resident removed her right leg from underneath herself and was observed rubbing her right leg. Approximately three minutes after the fall, AP1 found the resident and requested assistance from AP2 to lift the resident off the ground. When attempting to lift the resident off the ground, the resident was visibly not able to bear any weight so AP1 and AP brought the resident to the nearest chair, got a wheelchair, and pushed the resident in the wheelchair back to her room.

The taped camera footage from the resident's room the night of the incident was reviewed. AP1 and AP2 brought the resident into her room in a wheelchair. AP1 and AP2 attempted to transfer the resident from the wheelchair to her bed. When the resident stood up, she was grunting and saying, "no, no!" The resident did not appear to move her right leg during the transfer as AP1 and AP2 attempted to pivot the resident to sit on the edge of the bed. As the resident continued to groan and repeat, "No, no," AP2 continued to repeat to the resident, "You're fine". The resident was sitting on the edge of the bed and AP2 grabbed the resident legs and lifted them into bed. The resident cried out and moaned and AP2 continued to repeat, "You're fine." When the resident was lying in bed AP2 touched and rubbed the resident's right leg and told AP1 to come and look at the resident's foot. AP2 asked AP1 if the residents leg felt, "weird?" While AP1 and AP2 were looking at the residents leg the resident propped herself up on her elbows and stated, "it's bad". AP1 was observed taking a picture of the resident's leg with a cell phone. The resident attempted to sit up in bed and AP1 and AP2 both told the resident she needed to stay lying down. AP2 stated, "You can't walk on that leg, you're going to fall down."

AP1 and AP2 continued to discuss what to do while the resident continued to attempt to sit up in bed. AP1 continued to sit on the edge of the resident's bed and rub the resident's leg when AP2 walked out of the room. AP1 lifted both of the residents' legs to scoot them over in bed so the resident was lying flat. The resident was moaning during the move. AP1 left the room. AP1 and AP2 were not observed on the resident's camera checking on the resident for the remainder of their two-hour shift.

An incident report of the fall documented by AP1 indicated the resident was found sitting on the floor quietly. AP1 documented the resident had no pain and had no injuries.

AP1 documented in the resident's progress notes the evening of the fall the resident ate dinner well and took her meds. There was no documentation regarding the residents fall.

The evening of the residents falls, AP1 documented the resident's safety checks for 6:00 p.m., 8:00 p.m., and 10:00 p.m. were completed at 3:47 p.m.

Nurses' notes from the evening of the fall indicated the on-call nurse was contacted and staff reported the resident had an unwitnessed fall and was found on the floor in the common area. The notes indicated the resident had no injuries, did not hit her head, had no complaints of pain, and range of motion (ROM) and vitals were "stable."

AP3 was assigned to care for the resident the overnight shift following the fall. AP3 documented in the resident's medical record the "Resident slept well during the night shift and staff checked on her every two hours during rounds and staff assisted her with toileting, resident did not have a bowel movement, no complaints, no behaviors, no pain".

The resident's plan of care directed staff to complete safety checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. AP3 documented the residents safety checks for 12:00 a.m., 2:00 a.m., and 4:00 a.m. were completed at 12:56 a.m. The 6:00 a.m. safety check was documented as completed at 6:53 a.m.

The recording from the resident's room during the overnight shift following the incident was reviewed and the residents room door was observed opening a crack around 11:30 p.m. but no one entered the room or interacted with the resident. There was no further evidence AP3 went into the resident's room all night.

The residents nurse notes approximately 12 hours following the residents fall indicated staff reported the resident complained of pain in her right leg and was unable to stand up. The residents right shin "appears different, almost bow," according to the staff report. The note indicated the resident had an unwitnessed fall the prior evening, but no injuries were reported by staff. The nurse notified the family and sent the resident to the hospital for evaluation.

The resident's hospital notes indicated the resident had a deformity and pain in her right lower leg. The resident X-rays of her right leg determined there were fractures in her right tibia and fibula (lower leg bones) as well as second-fourth metatarsal (foot bones) fractures to her right foot. She was admitted to the hospital for further management of the fractures and pain control. The hospital notes indicated the resident was receiving the maximum amount of pain medication in an effort to manage her pain. The hospital notes indicated the orthopedic doctor recommended nonoperative management due to the residents' multiple medical conditions. The resident was admitted to hospice and discharged from the hospital back to the facility six days after admission.

When interviewed AP1 stated she found the resident on the floor at about 9:00 p.m. AP1 stated she could not tell if the resident was in pain, and she couldn't determine if the resident's leg looked any different. AP1 stated her and AP2 assisted the resident in a wheelchair after the fall because the resident could not stand. AP1 stated it was unusual for the resident to be unable to stand up, but she thought the resident was tired from her nighttime medication. AP1 stated she did not go back into the resident's room after she assisted the resident to bed following the fall. AP1 denied knowing anything was different with the resident's right leg following the fall.

During interview AP2 stated she assisted AP1 with lifting the resident off the floor following a fall. AP2 stated the resident started crying when they were trying to lift her off the floor, but she didn't notice any injury or think anything was different because the resident "cried often." AP2 stated the resident was brought back to her room in a wheelchair because she was unable to stand. AP2 stated she called the nurse to report the fall but did not tell the nurse about the resident's leg, or her inability to stand. AP2 stated the resident's leg "looked a little different" so she took pictures of the resident's leg with her cell phone, however, she did not send the picture to the nurse. AP2 stated she sent the picture of the resident's leg, after the resident was hospitalized, to a manager at the facility who was not a nurse.

When interviewed AP3 stated she had not been notified the resident fell prior to her shift. AP3 stated she completed all of the overnight cares except toileting. When AP3 was informed the resident's room camera did not pick up on any safety checks overnight, AP3 stated she just opened the door a little and saw the resident in her bed, so she didn't want to go in and wake her. AP3 said the resident was quiet all night and there was no indication the resident was in pain.

When interviewed the on-call nurse stated she received a call from AP2 reporting the resident fell. AP2 reported the resident had no pain, normal range of motion and vital signs, and had no head injury. The nurse stated AP2 never mentioned the resident was unable to stand or that her right leg looked abnormal.

During interview a facility nurse stated the morning following the residents fall staff called and reported the resident was crying, in a lot of pain, and her right leg looked bruised and bowed out. The nurse directed staff to send the resident to the hospital.

When interviewed a resident family member stated they noticed on the resident's room camera she appeared to be in pain when morning staff came in to assist the resident with cares. The family member could see the staff asking the resident what happened to her leg and why she wouldn't get out of bed. The family member stated the resident's room camera only turned on with movement, which includes when the room door opens. The night of the fall they watched the resident walk out of her room after 8:30 p.m. They saw AP1 and AP2 bring her back to the room in a wheelchair at 9:06 p.m. The residents room door was observed to open slightly around 11:30 p.m. the night of the fall, but after 11:30 p.m. there was no indication on the room camera staff opened the door or entered the room at all. The family member stated the resident always takes herself to the bathroom one or two times overnight, but she did not get out of bed at all that night. The next morning, facility staff reported to the family the abnormal appearance of the resident's leg and complaints of pain and the resident was sent to the hospital. The family member stated after the resident was hospitalized it took several days to get the residents pain under control. The family member stated the resident was not a candidate for surgery, was discharged back to the facility with end of life cares, and passed away approximately two weeks after the fall.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, resident expired.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted all staff training for falls, maltreatment reporting, and change of condition.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
White Bear Lake City Attorney
White Bear Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL322769138C/ HL322765323M #HL322761521C/#HL322766064M #HL322761668C/#HL322766184M On April 18, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL322761521C/#HL322766064M, and #HL322761668C/#HL322766184M, tag identification 2310, and 2360.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure assisted living services were provided based on the resident's needs and subject to accepted health care standards for one of one resident (R1) with a fall with leg injury, and one of one resident (R2) who was locked outside the facility for over six hours. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 2 R1's 90-day assessment dated August 30, 2022 indicated the resident had diagnoses of dementia and a history of falls. R1 received assistance with dressing, bathing, grooming, meals, medications, laundry, and housekeeping. R1's service plan directed staff to complete safety checks every two hours, and assist the resident with toileting two times overnight. The assessment indicated R1 was able to transfer on her own and did not use a wheelchair for mobility. R1's most recent assessment dated April 12, 2023, indicated the resident had impaired judgement and difficulty communicating. A facility document titled, "incident report", dated April 6, 2023, indicated R1 had an unwitnessed fall at approximately 9:00 p.m. The report indicated the resident had no pain, and the nurse was notified. A facility report dated April 7th, 2023, titled, Investigation for R1's incident on April 6, 2023, indicated the facility camera footage was reviewed of R1's fall. At 8:57 p.m. on April 6, 2023, R1 was observed landing on her bottom with her right leg pinned beneath her. R1 removed her right leg from underneath herself. R1 was observed rubbing her right leg. At approximately 9:00 p.m., unlicensed personnel (ULP)-F found the resident on the floor and ULP-E came to assist ULP-F to lift R1 off the floor. R1 was visibly unable to bear weight, so ULP-F and ULP-E assisted R1 to the nearest chair and obtained a wheelchair to bring R1 to her room. The taped camera footage in R1's room from April 6, 2023, at 9:06 p.m. was reviewed. ULP-F	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 3 and ULP-E brought R1 into her room in a wheelchair. ULP-F and ULP-E attempted to transfer R1 from the wheelchair to her bed. When R1 stood up she was grunting and saying, "no, no!" R1 did not appear to move her right leg during the transfer as ULP-F and ULP-E attempted to pivoted the resident to sit on the edge of the bed. As R1 continued to groan and and state, "No, no," ULP-E continued to repeat to R1, "You're fine". R1 was sitting on the edge of the bed and ULP-E grabbed R1's legs and lifted them into bed. R1 cried out and moaned.. ULP-F continued to repeat to R1, "You're fine." When R1 was laying in bed ULP-E touched and rubbed R1's right leg and told ULP-F, "come see her [R1] foot", ULP-F asked ULP-E if R1's right leg, "feel weird?" While ULP-F and ULP-E were looking at R1's leg, R1 propped herself up on her elbows and stated, "it's bad". ULP-E was observed taking a cellular phone out and taking a picture of R1's leg. R1 attempted to sit up in bed and ULP-F and ULP-E both told the resident she needed to stay laying down. ULP-F stated, "You can't walk on that leg, you're going to fall down." ULP-F and ULP-E continued to discuss what to do while R1 continued to attempt to sit up in bed. ULP-F sat on the edge of R1's bed next to the resident and continued to rub R1's right leg and ULP-E left R1's room. ULP-F lifted both of R1's legs straight into bed so R1 was lying flat. R1 was moaning during the move. ULP-F left R1's room. R1's nurses' notes dated April 6, 2023, at 9:47 p.m. indicated the nurse was notified of an unwitnessed fall with "no injuries, no head strike, no reports of pain. R1's range of motion and vital signs were stable and indicated staff would continue to monitor R1. R1's progress notes written by ULP-F and dated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 4 April 6, 2023 at 8:10 p.m. stated R1, "ate her dinner well and took her meds." There was no documention regarding R1's fall. The overnight notes documented by ULP-D on April 7, 2023 at 6:52 a.m., indicated R1 "slept well during the night shift and staff checked on her every two hours during rounds and staff assisted her with toileting, resident did not have a bowel movement, no complaints, no behaviors, no pain". ULP-D documented R1 was assisted to the bathroom three times on her shift. R1's nurses' notes dated April 7, 2023, at 9:06 a.m., indicated, "Received report that resident [R1] complained of pain in right leg, unable to stand up. Right shin appears different, almost bow, per staff. Resident had an unwitnessed fall last evening but did not have injury per report." The nurses notes indicated R1 was sent to the hospital via ambulance and family was notified. When interviewed on April 25, 2023, at 9:13 a.m., ULP-F stated she assisted R1 off the floor following the fall. ULP-F stated she could not tell if R1 was in pain or if the residents leg looked any different than normal. ULP-F stated R1 was transferred to her room with a wheelchair after the fall because R1 was unable to stand. ULP-F stated she did not see R1 after she assisted the resident to bed following the fall. During an interview on April 26, 2023, at 9:59 a.m., ULP-E stated she assisted R1 off the floor following the fall. ULP-E stated R1 started crying when they were trying to lift her off the floor, however, ULP-E stated she didn't think anything was different because R1 "cried often." ULP-E stated ULP-F obtained a wheelchair to transfer R1 to her room because R1 was unable to stand.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 5 ULP-E stated she called the nurse to report R1's fall but did not tell the nurse about R1's leg or her inability to stand. ULP-E stated she took a picture of R1's leg but did not send it to the nurse. ULP-E stated she sent the picture to a facility manager who was not the facility nurse. During interview on April 26, 2023, at 3:30 p.m., ULP-D stated she was not aware R1 had a fall earlier that evening. ULP-D stated she completed safety checks on R1 every 2 hours overnight, however, she did not toilet R1. ULP-D stated R1 was quiet all night. R1's hospital notes dated April 12, 2023, indicated R1 had fractures to her right tibia and fibula (lower leg bones), and second-fourth metatarsal (foot bones) fractures to her right foot. The hospital notes indicated the orthopedic doctor recommended nonoperative management related to R1's multiple medical conditions. R1 was admitted to hospice and sent back to the facility on April 12, 2023. R1 passed away from her injuries April 18, 2023. During an interview on April 25, 2023, at 9:52 a.m. RN-C stated she was contacted by ULP-E on April 6, 2023, and notified R1 had a fall. RN-C stated ULP-E reported R1 was found on the floor after having an unwitnessed fall. ULP-E reported R1 had no injuries, no pain, did not hit her head, and R1's vital signs and range of motion were normal. During interview on April 19, 2023, at 1:00 p.m, RN-B stated she was the on call nurse the morning following R1's fall. RN-B stated a staff member went to complete morning cares on R1 and the resident, "appeared to be in pain," and the resident was not moving as she usually did.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 6 During an interview on April 28, 2023, at 11:09 a.m., R1's family member (FM) stated they viewed the camera footage from R1's room after R1's fall on April 6th and throughout the night of April 7th. The family member stated the camera in the residents room turns on and starts recording with any motion or when the door to the room is opened. The recorded video indicated after the fall, R1's door was opened slightly around 11:30 p.m. on April 6, 2023. However, no further checks of the resident were recorded overnight. . A facility document (undated) titled "steps to follow when a resident falls" details a list of things to do when a resident falls. The document indicated, "Do not get the resident off the ground before the nurse gives the "okay"". The steps detail to call the nurse and "follow nurse instructions for next steps". Step six is to "assist the resident off the floor when instructed by the nurse". The final step is to, "chart in the progress note that the resident had a fall". R2 R2's service plan March 1, 2021, indicated the resident required assistance with dressing, bathing, grooming, meals, medications, laundry, and housekeeping. Staff were directed to complete safety checks every two hours. R2's most recent assessment dated April 12, 2023, indicated the resident was confused and had impaired balance when standing and walking. A facility document dated April 15, 2023, titled, "Investigation for [R2] incident on April 14-15,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 7 2023, indicated staff were completing safety checks around 1:00 a.m. on April 15, 2023, and R2 was not in her room. Staff began to search and found R2 on her back lying on the ground in the courtyard. R2's lower half of her body was on concrete and R2's head was on the landscape rock. 911 was contacted and R2 was transported to the hospital for evaluation. The document indicated the facility camera footage from the evening of April 14, 2023, was reviewed and R2 was observed going out into the courtyard around 6:48 p.m. R2's service record dated April 14, 2023, indicated ULP-B documented completing safety checks for R2 at 7:00 p.m. and 9:00 p.m. ULP-B documented the 7:00 p.m. safety check occurred at 3:35 p.m. and the 9:00 p.m. safety check occurred at 7:24 p.m. ULP-B charted R2 was assisted with night-time cares and toileted prior to the end of ULP-B's shift at 11:00 p.m. ULP-B documented, "The resident ate 98% of her dinner and she went into her room to sleep." The next shift started at 11:00 p.m. and ULP-C charted the 11:00 p.m. safety check was "not done". During interview on May 3, 2023, at 3:35 p.m., ULP-B stated he locked the courtyard doors at 8:00 p.m., however, he did not go out into the courtyard to ensure all of the residents were in the building. ULP-B stated the last time he saw R2 on April 14, 2023, was approximately 6:50 p.m. ULP-B stated he went to R2's room but her door was locked so he thought R2 was in her room. ULP-B stated R2's evening cares and safety checks were not completed the evening of April 14, 2023. R2's hospital notes dated April 15, 2023, indicated R2 was treated in the Emergency room	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32276	A. BUILDING: _____ B. WING _____	C 04/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 8 for a urinary tract infection. R2 was prescribed oral antibiotics and sent back to the facility on April 15, 2023. During an interview on April 26, 2023, at 11:31 a.m., administrator (A)-A stated staff were instructed to walk the premises of the courtyard prior to locking the doors around 8:00 p.m. No further information was provided. Time period for correction: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	