Electronically Delivered
February 18, 2025

Licensee
Lilac Homes Enhanced Assisted Living Memory Care
1500 Southwood Drive
Dilworth, MN 56529

RE: Project Number(s) SL34812016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34812 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL34812016-0<br><br>On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 34 residents; 34 receiving services under the Assisted Living Facility with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 340 | Continued From page 1 | 0 340 | | |
| 0 340 SS=F | 144G.30 Subd. 5 Correction orders<br><br>(a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.<br>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.<br>(c) By the correction order date, the facility must:<br>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0470, 0660, 1540) for a survey completed on July 7, 2022. This had the potential to affect all residents, staff, and visitors at the facility.<br><br>This practice resulted in a level two violation (a | 0 340 | | |

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| 0 340 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 10:05 a.m., licensed practical nurse (LPN)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>The licensee provided an undated Plan of Correction, which consisted of two pages including the following information:<br>-0470: Staffing plan created by RN (registered nurse) and will be reviewed every six months or sooner if needed;<br>-0660: As of July 5, 2022, Facility Risk Assessment [sic] was completed and will be completed annually if medium risk or every two years for low risk; and<br>1540: The Guide to Assisted Living and Dementia Training [sic] have been completed by all current staff as well as required education. Upon hire, all staff will complete all required training prior to working with residents.<br><br>The licensee lacked documentation to indicate correction orders previously cited on July 7, 2022, were in full compliance with assisted living with dementia care statutes.<br><br>On January 7, 2025, at 3:25 p.m., LPN-A and LPN-J stated the plan of correction provided to the surveyor was documentation of what actions the licensee took to correct correction orders for a | 0 340 | | |

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| 0 340 | Continued From page 3<br>survey completed on July 7, 2022.<br><br>On January 8, 2025, the survey concluded, and correction orders 0470, 0660, and 1540 were reissued.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 340 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the | 0 470 | | |

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| 0 470 | Continued From page 4<br><br>appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living with dementia care license and was licensed for a capacity of 36 residents, with a current census of 34 residents.<br><br>During the entrance conference on January 6, 2025, at 10:05 a.m., licensed practical nurse (LPN)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>The licensee's Direct Care Staffing Plan dated January 8, 2024, indicated CNS-B developed and implemented the written staffing plan, however, the Direct Care Staffing Plan lacked documentation the staffing plan had been | 0 470 | | |

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| 0 470 | Continued From page 5<br>reviewed at least twice per year.<br><br>On January 6, 2025, at 2:12 p.m., registered nurse (RN)-C stated RN-C was unable to locate the licensee's documentation of the staffing plan being reviewed at least twice per year, however, RN-C stated the licensee's resident census did not change much, and the staffing plan would be reviewed with a change in the resident census or staff requesting additional unlicensed personnel (ULP) to be scheduled to meet the needs of resident cares.<br><br>The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated September 26, 2024, indicated a CNS, or designee, will develop, write, and implement a staffing plan. In addition, the staffing plan will be evaluated for the appropriately [sic] of staffing levels in the facility and reviewed as needed at a minimum of two times per year.<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with | 0 480 | | |

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| 0 480 | Continued From page 6<br>one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part | 0 480 | | |

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| 0 480 | Continued From page 7<br>4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for three of five employees (unlicensed personnel (ULP)-F, ULP-H, ULP-I) during medication administration and resident cares. In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable resident medical equipment for one of one employee (ULP-H).<br><br>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).<br><br>The findings include:<br><br>HAND HYGIENE<br>MEDICATION ADMINISTRATION<br>On January 7, 2025, at 7:40 a.m., the surveyor observed ULP-F complete morning scheduled medications for R8. ULP-F donned gloves, applied Aquaphor (moisturizer) to R8's arms and legs, with the same gloved hands, ULP-F applied | 0 510 | | |

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| 0 510 | Continued From page 9<br><br>Diclofenac gel (pain gel) to R8's lower back, and ULP-F doffed gloves. ULP-F donned new gloves, administered R8's eye drops, and without changing gloves, set-up R8's nebulizer equipment (breathing treatment). ULP-F doffed gloves, administered R8's nebulizer medication, ULP-F donned new gloves, rinsed R8's nebulizer equipment, ULP-F doffed gloves, and ULP-F washed ULP-F's hands with water only. The surveyor did not observe ULP-F complete hand hygiene in between glove changes or at the completion of R8's care.<br><br>On January 7, 2025, at 8:49 a.m., the surveyor observed ULP-H complete scheduled morning medication administration for R4, and ULP-H returned to the computer to document in R4's electronic medications administration record (EMAR). The surveyor did not observe ULP-H complete hand hygiene before or after medication administration for R4.<br><br>RESIDENT CARES<br>On January 7, 2025, at 9:17 a.m., the surveyor observed ULP-H and ULP-I enter R5's room, without completing hand hygiene, ULP-H and ULP-I put on gloves, and ULP-H and ULP-I assisted R5 to sit up on side of R5's bed. R5 stated R5 wanted to lay back down, and ULP-H and ULP-I assisted R5 to lay back down in bed to change R5's brief. With gloved hands, ULP-I wiped R5's peri area, with the same gloved hand ULP-I applied barrier cream to R5's peri area, and then placed a new brief on R5. ULP-I stated to ULP-H, R5's "soaker pad" (absorbent pad designed for use with incontinence) was soiled with urine and needed to be replaced with a new soaker pad. With gloved hands, ULP-H checked R5's closet for a clean soaker pad, ULP-H left R5's room, went to the laundry room, took off | 0 510 | | |

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| | 34812 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 510 | Continued From page 10<br><br>gloves, without hand hygiene served R10 breakfast in the dining room, and returned to R5's room without completing hand hygiene. Without gloved hands, ULP-H removed R5's soiled soaker pad, ULP-I placed a disposable soaker pad under R5, ULP-H covered R5 with blankets, and ULP-I doffed gloves. ULP-H and ULP-I left R5's room and the surveyor did not observe ULP-H or ULP-I complete hand hygiene when both staff exited the R5's room.<br><br>SHARED REUSABLE MEDICAL EQUIPMENT/HAND HYGIENE<br>On January 7, 2025, at 10:52 a.m., the surveyor observed ULP-H bring the sit-to-stand lift with the transfer sling draped over the lift into R11's room. The surveyor did not observe ULP-H disinfect the sit-to-stand lift or sling. Without hand hygiene or donned gloves, ULP-H placed the sling behind R11, transferred R11 to the toilet via sit-to-stand lift, removed R11's brief, and placed a new brief on R11. Without performing hand hygiene, ULP-H made R11's bed while R11 was toileting. Without performing hand hygiene, ULP-H donned gloves, wiped R11's peri area, removed gloves without hand hygiene, pulled up R11's brief and pants, and transferred R11 back to R11's wheelchair via the sit-to-stand lift. ULP-H returned to R11's bathroom, without donned gloves, ULP-H wiped urine off R11's toilet seat, took out R11's garbage, placed the sling over the sit-to-stand, grabbed the handles on the sit-to-stand lift, and pushed the sit-to-stand out to the hallway. The surveyor did not observe ULP-H complete hand hygiene or disinfect the shared resident sit-to-stand lift and sling.<br><br>On January 7, 2025, at 11:04 a.m., ULP-H stated multiple residents used the sit-to-stand lift and the sling was shared among residents. ULP-H stated | 0 510 | | |

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| 0 510 | Continued From page 11<br><br>ULP-H did not disinfect the sling or sit-to-stand lift before or after each resident use as the night shift was supposed to disinfect the equipment. ULP-H further stated ULP-H should have completed hand hygiene before donning gloves and after doffing gloves along with entering and exiting resident rooms.<br><br>On January 7, 2025, at 11:14 a.m., ULP-I stated the shared resident sit-to-stand lift and sling did not get disinfected after each resident use since night staff disinfect the lift and sling at night. ULP-I further stated ULP-I was trained to wash hands before and after the use of gloves.<br><br>On January 7, 2025, at 11:17 a.m., ULP-G stated shared reusable medical equipment was not disinfected between each resident use. ULP-G further stated ULPs were trained to complete hand hygiene before and after resident cares, medication administration, and in-between glove use.<br><br>On January 7, 2025, at 11:39 a.m., registered nurse (RN)-C stated ULPs were trained to complete hand hygiene upon entering and exiting resident rooms, in-between glove changes, and prior to resident medication administration. Licensed practical nurse (LPN)-A stated ULPs were trained to wear gloves when potential to blood or bodily fluids was likely. RN-C and LPN-A further stated ULPs were trained to disinfectant shared reusable medical equipment with multipurpose disinfectant wipes after each resident use.<br><br>The licensee's Hand Hygiene policy dated December 28, 2022, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident | 0 510 | | |

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| 0 510 | Continued From page 12<br><br>takes place. Use of gloves does not replace hand washing. In addition, apply soap over hands and wrists, working into a generous lather by scrubbing vigorously for at least 20 seconds.<br><br>The licensee's Procedure for Using Gloves policy dated December 28, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item. In addition, the policy indicated to wash hands before applying gloves and rewash hands after removing gloves.<br><br>The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated January 8, 2024, indicated after using reusable equipment, the equipment must be cleaned and returned to the place that it is stored.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled | 0 660 | | |

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| 0 660 | Continued From page 13<br><br>volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>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) and Minnesota Department of Health (MDH), which included completion of an annual TB facility risk assessment.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 10:05 a.m., licensed practical nurse (LPN)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated October 30, 2023, was completed by clinical nurse supervisor (CNS)-B. On page three, section: Quality Improvement 2: had written "Guidelines are now annual" for how frequently the TB risk assessment worksheet was | 0 660 | | |

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| 0 660 | Continued From page 14<br>conducted or updated by the licensee.<br><br>On January 7, 2025, at 11:38 a.m., registered nurse (RN)-C stated the licensee had not completed an updated facility TB risk assessment worksheet since October 30, 2023, and RN-C was not aware the facility TB risk assessment needed to be completed on an annual basis since CNS-B was responsible to complete the facility TB risk assessment for the licensee.<br><br>The licensee's TB Prevention and Control policy dated September 27, 2024, indicated the CNS was responsible for completion of a written TB risk assessment for the agency using the form provided by the [sic] MDH. In addition, annual review and revision as needed of the TB risk assessment for the facility.<br><br>The MDH guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated June 10, 2019, and based on CDC guidelines, indicated a facility TB risk assessment should be completed initially and on an annual basis.<br><br>The MDH Assisted Living Resources and Frequently Asked Questions (FAQs) last updated December 13, 2024, indicated each provider licensed by MDH is required to complete a TB risk assessment annually.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness | 0 680 | | |

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| 0 680 | Continued From page 15<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors of the facility.<br><br>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 | 0 680 | | |

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| 0 680 | Continued From page 16<br><br>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's EPP dated January 16, 2024, lacked the following content and/or policies and procedures to address:<br>- development of policy/procedure to address emergency staffing strategies including surge planning and use of volunteers;<br>- policy/procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; and<br>- must conduct exercises to test the EPP at least twice per year.<br><br>On January 8, 2025, at 12:01 p.m., agent (A)-K stated a table-top drill was completed with (name) Ambulance, another drill was completed with Clay County, and evidence would be sent to surveyor. A-K further stated the licensee was not aware of the requirement for providing services under the 1135 waiver from the Secretary of State, and the licensee would not use volunteers.<br><br>On January 8, 2025, at 1:20 p.m., additional documentation was provided by A-K, however, failed to provide evidence of above noted requirements.<br><br>The licensee's Emergency and Disaster Preparedness policy dated October 17, 2024, did not address providing services in accordance with the 1135 waiver. The policy indicated training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles and the facility conducts exercises to test the EPP at least twice per year. | 0 680 | | |

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| 0 680 | Continued From page 17<br><br>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 700 SS=F | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private for four of four nursing computers. This had the potential to affect all residents. | 0 700 | | |

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| 0 700 | Continued From page 18<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 10:05 a.m., licensed practical nurse (LPN)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>On January 7, 2025, at 7:29 a.m., the surveyor observed unlicensed personnel (ULP)-G's computer unattended with the computer screen open and resident information visible.<br><br>On January 7, 2025, at 8:24 a.m., the surveyor observed ULP-H's computer unattended with the computer screen open and resident information visible.<br><br>On January 7, 2025, at 8:25 a.m., the surveyor observed ULP-F's computer unattended with the computer screen open and resident information visible.<br><br>On January 7, 2025, at 8:53 a.m., the surveyor observed ULP-H's computer unattended with the computer screen open with R4's medications listed on the screen.<br><br>On January 7, 2025, at 8:51 a.m., the surveyor observed ULP-E's computer unattended with the | 0 700 | | |

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| 0 700 | Continued From page 19<br><br>computer screen open and resident information visible.<br><br>On January 7, 2025, at 11:11 a.m., ULP-H stated ULP-H did not shut the computer screen or close out private resident health information anytime ULP-H would go to a resident room. ULP-H further stated any resident, staff, or visitor would be able to view private resident health information when the computer screen was left open.<br><br>On January 7, 2025, at 11:19 a.m., ULP-G stated ULPs were trained to close computer screens that contained private resident health information anytime the computer was not in use, however, ULP-G stated during the "mid-morning rush" ULP-G would not always close the computer screen when not in use.<br><br>On January 7, 2025, at 11:47 a.m., registered nurse (RN)-B stated resident information on computers was confidential information and anytime a ULP left a computer unattended, the ULP needed to close the computer screen or log out of the resident's electronic medical record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 700 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate | 0 780 | | |

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| 0 780 | Continued From page 20<br><br>sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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). | 0 780 | | |

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| 0 780 | Continued From page 21<br><br>Findings include:<br><br>On January 7, 2025, at 10:10 a.m., survey staff toured the facility with registered nurse (RN)-C, it was observed that the emergency exit doors 4, 5 and 6, going out to the courtyard, had gates that were locked and required to be unlocked manually which removes a safe means of egress during a fire or similar emergency. These emergency exit doors were identified with overhead exit signs and are included in the facility's evacuation plan.<br><br>RN-C verbally confirmed survey staff observation.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 0 790 | | |

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| 0 790 | Continued From page 22<br><br>failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>On January 07, 2025, at 10:15 a.m., survey staff conducted a facility tour with registered nurse (RN)-C, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order.<br><br>RN-C stated they understood the requirements.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms; | 0 810 | | |

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| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

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| 0 810 | Continued From page 23<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 24<br><br>resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 8, 2025, at 4:21 p.m., agent (A)-K provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br><br>Survey staff reviewed the fire evacuation diagrams and observed that they did not include label descriptions where the emergency exits were located. The map had arrows and symbols where the exits were but no label explaining what those arrows and symbols represent. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency.<br><br>Survey staff observed the fire safety and evacuation plan was not located in a central location for all staff accessibility.<br><br>A-K stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.<br><br>DRILLS:<br>The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated evacuation drills were conducted on | 0 810 | | |

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| 0 810 | Continued From page 25<br><br>June 18, 2024, and September 13, 2024. No other documentation was provided.<br><br>A-K stated that they were doing the evacuation drills quarterly and A-K understood the requirements for employees twice per year, per shift with at least one evacuation drill every other month.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01540 SS=F | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(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 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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two | 01540 | | |

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| 01540 | Continued From page 26<br><br>employees (unlicensed personnel (ULP)-G) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living with dementia care license effective June 1, 2024, with an expiration date of May 31, 2025.<br><br>During the entrance conference on January 6, 2025, at 10:43 a.m., human resource director (HRD)-D stated the licensee was aware of the required contents of the employee record.<br><br>ULP-G was hired on September 6, 2024, to provide direct care to the residents at the facility.<br><br>On January 7, 2025, at 7:47 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R7.<br><br>ULP-G's employee record documented ULP-G had completed 6.5 hours of dementia training. ULP-G's employee record lacked the required eight (8) hours of dementia training within 80 hours of the employee's start date.<br><br>On January 8, 2025, at 11:51 a.m., clinical nurse supervisor (CNS)-B stated ULP-G was short 1.5 hours of dementia training to be completed within | 01540 | | |

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| 01540 | Continued From page 27<br><br>80 hours of ULP-G's employment start date. CNS-B further stated the same 6.5 hours of initial dementia training was assigned for all new employees and CNS-B was not sure how the licensee had missed assigning an additional 1.5 hours of dementia training upon hire of employment with the licensee.<br><br>The licensee's Assisted Living with Memory Care Dementia Training policy dated January 8, 2024, indicated Assisted Living with Dementia Care licensed settings will have direct-care employees complete a minimum of eight hours of initial training on dementia care topics within 80 working hours of the employment start date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01540 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure two of two refrigerators storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature.<br><br>This practice resulted in a level two violation (a | 01880 | | |

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| 01880 | Continued From page 28<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 10:11 a.m., licensed practical nurse (LPN)-A stated the licensee provided medication management services to the residents at the facility.<br><br>The facility layout consisted of two secured (required a keypad to enter and exit the unit) units (enhanced assisted living, memory care).<br><br>On January 7, 2025, at 8:01 a.m., the surveyor observed the enhanced assisted living medication refrigerator with unlicensed personnel (ULP)-G. ULP-G stated the current refrigerator temperature was 44 degrees Fahrenheit (F), ULP-G was not directed to check the refrigerator temperature daily, and the refrigerator contained the following:<br>-four unopened Fiasp 100 units/milliliter (mL) Flex Touch insulin pens for R9<br>-three unopened Basaglar 100 units/mL insulin pens for R9<br><br>On January 7, 2025, at 9:10 a.m., the surveyor observed the memory care medication refrigerator with a thermometer reading four degrees F and the refrigerator contained the following:<br>-one unopened cyanocobalamin injection for R12<br>-18 sealed individual applesauce cups<br>-one opened applesauce cup | 01880 | | |

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| 01880 | Continued From page 29<br><br>-unknown product (appeared to be food) in tinfoil<br>-Temp Stick (electronic thermometer module to record the refrigerator's current temperature)<br><br>The licensee's undated Temp Stick module indicated the licensee would be notified if medication refrigerators were not between 36 degrees F and 47 degrees F.<br><br>On January 7, 2025, at 9:12 a.m., ULP-E and ULP-F stated ULPs do not monitor medication refrigerator temperatures.<br><br>On January 7, 2025, at 9:14 a.m., LPN-A stated LPNs do not monitor medication refrigerator temperatures.<br><br>On January 7, 2025, at 9:20 a.m., LPN-J stated agent (A)-K has an application (app) (electronic program) on A-K's cell phone which received temperature readings from each of the medication refrigerators.<br><br>On January 8, 2025, at 11:56 a.m., A-K stated the Temp Stick was not working properly, A-K was unsure when the Temp Stick sensor stopped communicating with the app on A-K's phone, and A-K confirmed the parameters of the Temp Stick module were 36 degrees F to 47 degrees F. A-K further stated, the licensee did not have a procedure in place to notify nursing staff if the medication refrigerator temperatures were out of range.<br><br>On January 8, 2025, at 11:59 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware that cyanocobalamin injection should be stored at room temperature.<br><br>The manufacturer's instructions for Fiasp insulin | 01880 | | |

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| 01880 | Continued From page 30<br><br>pens dated July 2023, indicated to store unopened Fiasp insulin pens in the refrigerator at 36 degrees F to 46 degrees F or at room temperature below 86 degrees F.<br><br>The manufacturer's instructions for Basaglar insulin pens dated November 2022, indicated to store unopened Basaglar insulin pens in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Basaglar to freeze.<br><br>The manufacturer's instructions for cyanocobalamin injection dated January 2021, indicated to store cyanocobalamin injection between 68 degrees F to 77 degrees F.<br><br>The licensee's Storage of Medications policy dated December 27, 2022, indicated resident's medications will be stored according to manufacturer's recommendations.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service | 01910 | | |

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| 01910 | Continued From page 31<br><br>contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 10:11 a.m., licensed practical nurse (LPN)-A stated the licensee provided medication management services to residents at the facility.<br><br>The licensee's Discharged Resident/Client Roster dated January 6, 2025, indicated R1 was admitted to the facility on May 1, 2023, and discharged on September 30, 2024. | 01910 | | |

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| 01910 | Continued From page 32<br><br>R1's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness).<br><br>R1's service plan dated April 1, 2024, indicated R1 received medication administration two times per day.<br><br>R1's Discharge/Transfer Summary dated September 30, 2024, indicated R1 was discharged to [licensee name] nursing home.<br><br>R1's Medication Disposition-Resident dated September 30, 2024, lacked prescription numbers for Duloxetine (anti-depressant), Levetiracetam (anti-seizure), Nystatin Powder (anti-fungal powder), and Xarelto (blood thinner). In addition, the Medication Disposition-Resident lacked accurate pill counts for all prescriptions.<br><br>On January 6, 2025, at 1:42 p.m., LPN-J stated medication disposition should include the date, prescription name and number, quantity of pills remaining, and who the medications are being given to. LPN-J further stated LPN-J was unable to complete the process accurately due to R1's family removing medications from the facility prior to R1's discharge on September 30, 2024.<br><br>On January 6, 2025, at 2:52 p.m., registered nurse (RN)-C stated RN-C did not normally deal with medication disposition at resident discharge due to LPNs completing the medication disposition requirement.<br><br>The licensee's Disposition or Disposal of Medication policy dated December 27, 2022, indicated staff will document the disposition or disposal of medications in the resident's record. | 01910 | | |

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| 01910 | Continued From page 33<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; | 02170 | | |

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| 02170 | Continued From page 34<br><br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for three of three residents (R2, R3, R4) who resided in an assisted living with dementia care facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee held an assisted living with dementia care license effective June 1, 2024, with an expiration date of May 31, 2025.<br><br>R2<br>R2's diagnoses included anxiety disorder, atrial fibrillation (irregular heartbeat), and osteoporosis (weak bones).<br><br>R2's Service Plan dated March 26, 2024, indicated R2's services included medication management, behavior management, laundry, housekeeping, and assistance with bathing, grooming, dressing, transferring and toileting. | 02170 | | |

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|---|---|---|---|
| | 34812 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 35<br><br>On January 7, 2025, at 8:30 a.m., surveyor observed unlicensed personnel (ULP)-F complete scheduled morning medication administration for R2.<br><br>R2's Individualized Activity Plan dated October 22, 2024, included an evaluation of the activity areas which are required, however, R2's record did not include an individualized activity plan specific for R2.<br><br>R3<br>R3's diagnoses included cerebral infarction (death of brain matter from lack of blood flow and oxygen), diabetes, depression, and hypertension (elevated blood pressure).<br><br>R3's Service Plan dated June 30, 2024, indicated R3's services included medication management, behavior management, laundry, housekeeping, diabetic nail care, and assistance with bathing, grooming, dressing, transferring, and toileting.<br><br>On January 7, 2025, at 8:12 a.m., surveyor observed ULP-E complete scheduled morning medication administration.<br><br>R3's Individualized Activity Plan dated November 7, 2024, included an evaluation of the activity areas which are required, however, R3's record did not include an individualized activity plan specific for R3.<br><br>R4<br>R4's diagnoses included vascular dementia, Parkinson's disease, and diabetes.<br><br>R4's Service Plan dated September 23, 2024, indicated R4's services included medication | 02170 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34812 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 36<br><br>administration, blood glucose checks, and assistance with bathing, grooming, dressing, and transfers.<br><br>On January 7, 2025, at 8:53 a.m., the surveyor observed ULP-H complete scheduled morning medication administration for R4.<br><br>R4's Individualized Activity Plan dated December 17, 2024, included an evaluation of the activity areas which are required, however, R4's record did not include an individualized activity plan specific for R4.<br><br>On January 7, 2025, at 2:02 p.m., registered nurse (RN)-C stated the same Individual Activity Plan was used for all residents to determine the resident's preferences, interests, and limitations. RN-C further stated a formal individualized activity plan based off this evaluation had not been developed for any resident and RN-C was not aware an indiviualized activity plan needed to be developed based off the individualized evaluation.<br><br>On January 7, 2025, at 2:31 p.m., activities director (AD)-L stated the licensee provided group activities to residents throughout the day. AD-L further stated AD-L had completed some individual activities for specific residents, however, AD-L had not documented individualized activity plans for any residents.<br><br>The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC (assisted living dementia care) policy dated August 25, 2023, indicated an individualized activity plan will be developed for those (residents) receiving assisted living services based on their activity evaluation. | 02170 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34812 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LILAC HOMES ENHANCED ASSISTED LIVING | 1500 SOUTHWOOD DRIVE DILWORTH, MN 56529 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 37<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02170 | | |

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St Paul, MN, 55164
218-332-5150

Type: Full
Date: *01/06/25*
Time: 05:55:19
Report: 1042241066

# Food and Beverage Establishment Inspection Report



**Location:**
Lilac Home Enh As Liv Mem Care
1500 Southwood Drive
Dilworth, MN56529
Clay County, 14

**Establishment Info:**
ID #: 0039417
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2184432426
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.

**2-100 Supervision**

***2-102.12AMN***

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Discussed during visit.

*Comply By: 06/09/25*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 300ppm at Degrees Fahrenheit
Location: 3 compartment sink dispenser.
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 37.9 Degrees Fahrenheit - Location: Creamer
Violation Issued: No

Process/Item: Hot Holding
Temperature: 196.6 Degrees Fahrenheit - Location: Vegetable Mix
Violation Issued: No

Process/Item: Hot Holding
Temperature: 207.0 Degrees Fahrenheit - Location: Meatball and Gravy
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38.2 Degrees Fahrenheit - Location: Orange Juice
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 05:55:19
Report: 1042241066
Lilac Home Enh As Liv Mem Care

# Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 36.9 Degrees Fahrenheit - Location: Apple Juice
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38.8 Degrees Fahrenheit - Location: Salami
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37.1 Degrees Fahrenheit - Location: Mayonnaise
Violation Issued: No

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

- Post or Employ CFPM- Send ServSafe score and documentation within 6 months of passing exam to MN Dept of Health with fee for documentation. See Certified Food Protection Manager information online for instructions.
- Weekly Wipe Inside of Ice Machine to combat limescale and hard-water buildup.
- Post hand washing signs at each hand sink in kitchens and kitchenette
-Label and date anything removed from original packaging and encourage residents to do so with their own food products in public spaces.

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

I acknowledge receipt of the MN Department of Health inspection report number 1042241066 of 01/06/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

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

Signed:_____
Establishment Representative

Signed:_____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us