Electronically Delivered

November 15, 2022

Administrator
Lilydale Senior Living
949 Sibley Memorial Highway
Lilydale, MN 55118

RE: Project Number(s) SL29018015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 5, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILYDALE SENIOR LIVING	949 SIBLEY MEMORIAL HIGHWAY LILYDALE, MN 55118

(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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29018015-0 On October 3, 2022, through October 5, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 105 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report dated October 3, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-G, ULP-F)) observed to provide personal cares and medication administration. 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	0 510		

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0 510	Continued From page 3 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-G On October 4, 2022, at approximately 8:30 a.m., ULP-G was observed to don gloves before assisting R5 in the bathroom. After R5 voided in the toilet, ULP-G helped R5 stand up with the grab bars. ULP-G cleansed R5's perineum area with wipes and threw them in the trash. Without removing the gloves and or hand washing, ULP-G positioned the wheelchair by grabbing the arm rests and the handles to position it behind R5 and began pulling up R5's clean brief and pants with the soiled gloves. ULP-G assisted R5 into the wheelchair and then removed the soiled gloves and washed hands. - ULP-G propelled R5 into the kitchen area of the unit to check blood sugar and administer medication to R5. ULP-G donned gloves before setting up glucometer supplies. ULP-G wiped the resident's finger then pricked it with a lancet. Blood sample result was "170." ULP-G removed test strip from glucometer machine and threw it away and placed the lancet in the sharps container. Without removing the soiled gloves and hand washing, ULP-G then grabbed the work phone, keys and papers which ULP's document medication administration on. ULP-G then removed the soiled gloves, locked up the medications and supplies and propelled R5 into the dining room area. ULP-G washed hands in the dining room area. ULP-F On October 4, 2022, at approximately 9:20 a.m., ULP-F was observed to assist R9 to the bathroom and assist with toileting, dressing and	0 510		

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0 510	Continued From page 4 grooming. ULP-F donned gloves to clean R9's perineum area with wipes and threw them in the trash. ULP-F pulled up R9's pants and touched the walker handles with soiled gloves. Once R9 grabbed the walker, ULP-F removed the gloves and threw them away, no hand washing was observed. On October 4, 2022, at approximately 12:00 p.m., ULP-F stated gloves should be removed after performing tasks and hand washing (hygiene) should be performed when gloves were removed. During an interview on October 4, 2022, at approximately 3:45 p.m., registered nurse (RN)-I and director of nursing (DON)-E stated gloves should be removed and hand washing/hygiene performed after completing tasks and prior to touching surfaces. The licensee's 8.07 Gloves policy dated August 1, 2021, directed gloves should be removed after handling contaminated material then wash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 5 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (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 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarm located outside within the immediate vicinity of a bedroom in apartment unit 405 and the interconnection of smoke alarms in apartment units 305, 302, and 105. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 5, 2022, approximately from 11:00	0 780		

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0 780	Continued From page 6 a.m. to 1:45 p.m., survey staff toured the facility with the Regional VP of Operations (RO)-B. During the tour, survey staff observed and the RO-B verified the following findings: 1) In resident the two-bedroom unit 405, no smoke alarm was provided outside within the immediate vicinity of one of the two bedrooms. 2) The smoke alarms located outside one of the two bedrooms inside apartment units 305, 205, and 105 were tested and the smoke alarms were not interconnected and failed to sound the other alarms inside the apartments for proper notification. The RO-B verified the findings as they investigated the three alarms that were not interconnected in units 305, 205, and 105 all were battery type but all other smoke alarms in the apartments were hardwired. On October 5, 2022, at approximately 2:30 p.m., during the exit interview, the RO-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 7 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the complete content on the fire safety and evacuation plan, the minimum frequency of employee evacuation drills, and the minimum required staff training on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. 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	0 810		

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0 810	Continued From page 8 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 5, 2022, at approximately 1:45 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review. Document review and interview with the Regional VP of Operations (RO)-B at approximately 2:00 p.m. indicated the following findings: FIRE SAFETY AND EVACUATION PLAN The fire safety and evacuation plan lacked complete fire protection procedures necessary to address unique resident-specific situations during an evacuation from fire or similar emergency. Survey staff explained to the RO-B that unique situations must be considered during an evacuation and could be residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. TRAINING The licensee had the correct policy on employee training on fire safety and evacuation plan but lacked records to substantiate employee training specifically on the fire safety and evacuation plan consisting of at least twice a year. FIRE and EVACUATION DRILLS The licensee failed to provide the minimum required evacuation drills for compliance with two	0 810		

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0 810	Continued From page 9 evacuation drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The drill record review showed drills were performed noting on, 7/27/2022, 6:45 a.m., 7/20/2022, 6:50 (NOC), 7/11/2022, 2:26 p.m., 6/14/2022, 8:40 (days), and 6/20/2022, 14:35 (days), and therefore, failed to meet the minimum requirement of one drill every other month. . On October 5, 2022, at approximately 2:30 p.m., during the exit interview, the RO-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.	0 970		

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0 970	Continued From page 10 This practice resulted in a level one violation and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Review of the licensee's assisted living contract identified the following: The assisted living contract included clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 23 Indemnification: indicated the resident "assumes the risk for resident's own safety and for the safety of resident's guests and agents. Resident will indemnify and hold harmless provider, its employees, officers, managers, owners, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of resident or resident's guest or agents." Page 15, section 25 Liability: indicated the "provider is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or provider's premises unless such injury, death or property damage occurs as a result of provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as a result of resident's receipt of	0 970		

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0 970	Continued From page 11 health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on provider's premises." On October 4, 2022, at 11:48 a.m., licensed assisted living director (LALD)-A confirmed the assisted living contract was used for all residents. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, verified the assisted living contract is a legal, binding contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILYDALE SENIOR LIVING	949 SIBLEY MEMORIAL HIGHWAY LILYDALE, MN 55118

(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
01370	Continued From page 12 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-G) received the required training/competency testing. 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	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 13 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally. The findings include: On October 4, 2022 at approximately 9:00 a.m., ULP-G was observed to propel R5 in a manual wheelchair to the common dining area without the use of foot pedals. Resident was observed to be required to hold their feet up under their own power. R5's Individualized Services Amendment dated October 1, 2021, indicated R5 received medication management, dressing, grooming, mobility and transfer assistance. ULP-G ULP-G began employment on November 1, 2012. ULP-G's HHA (home health aid) Training Check off List form dated October 19, 2012, lacked evidence of training in use of wheelchair with foot pedals in place. On October 4, 2022, at approximately 9:30 a.m., ULP-G stated at hire they were trained by the registered nurse (RN) on wheelchair use during orientation. ULP-G could not recall specific training on the use of footrests was provided but acknowledged wheelchair use was reviewed during their training. On October 4, 2022, at approximately 11:00 a.m., director of nursing (DON)-E and RN-I stated the expectation was for all wheelchairs to have foot pedals in place when residents were being propelled by staff.	01370		

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01370	Continued From page 14 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01370		
01880 SS=D	144G.71 Subd. 19 Storage of medications 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were properly secured for only authorized personnel for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 admitted to licensee on August 22, 2018, with a primary diagnosis of dementia. R5 received the following services: medication management, dressing and grooming, mobility and transfer assistance. R5 resided in a locked memory care unit.	01880		

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	29018	A. BUILDING: _____ B. WING _____	10/05/2022

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01880	Continued From page 15 On October 4, 2022, at approximately 9:00 a.m., unlicensed personnel (ULP)-G was observed to administer medications from a locked cabinet, including insulin. R5's refrigerator was observed to have three unopened Basaglar insulin pens in the refrigerator door. The refrigerator was not locked and ULP-G verified unauthorized personnel had access to the insulin. On October 4, 2022, at approximately 9:30 a.m., the director of nursing (DON)-E verified R5's refrigerator contained three Basaglar insulin pens and stated the insulin was not properly secured so only authorized personnel had access. The licensee's 7.10 Medication Storage policy dated August 1, 2021, indicated all medications would be kept securely locked within resident's private living space and only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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	29018	A. BUILDING: _____ B. WING _____	10/05/2022

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01890	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure expired medications were properly disposed of which had the potential to affect all residents receiving medication management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 4, 2022, at approximately 8:15 a.m., surveyor observed unlicensed personnel (ULP)-F and ULP-G administer medications to three residents. On October 4, 2022, at approximately 11:00 a.m., the registered nurse (RN)-I, stated the licensee provided house stock (over the counter medications available to any resident) medications to all residents who received medication management. On October 4, 2022, at approximately 12:15 p.m. RN-I, and director of nursing (DON)-E, observed expired house stock medications. RN-I and DON-E stated medications listed below were expired. -Acetaminophen 500mg (milligram) tablets expired on April 18, 2022 (Analgesic) -Siltussin DM expired September 2022 (for congestion) -Loperamide 2 mg tablets expired on September 2022 (anti-diarrheal)	01890		

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01890	Continued From page 17 The licensee's 7.22 Medication Disposal policy dated August 1, 2021, indicated expired medications would be disposed of and labels from the containers would be destroyed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 18 violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On October 5, 2022, approximately from 11:00 a.m. to 1:45 p.m., survey staff toured the facility with the Regional VP of Operations (RO)-B. On October 5, 2022, at approximately 2:15 p.m., a documentation review and interview were performed with the RO-B on the hazard vulnerability or safety risk assessment for the memory care physical environment indicated the following findings: 1) Review of the plan documentation indicated the licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the documentation provided for survey staff review was tittle, "Kaiser Permanente" and did not include site-specific vulnerability content on building and property safety risk assessments. 2) Review of the plan documentation indicated the licensee did not identify mitigations to protect memory care residents from harm. Prevention measures or mitigations must be developed and documented in the plan to address all potential hazard vulnerabilities for this property.	02040		

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02040	Continued From page 19 On October 5, 2022, at approximately 2:30 p.m., during the exit interview, the RO-B verified the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *10/03/22*
Time: 11:30:00
Report: 1031221154

Food and Beverage Establishment Inspection Report

Location:
Lilydale Senior Living
949 Sibley Memorial Highway
Lilydale, MN55118
Dakota County, 19

Establishment Info:
ID #: 0037891
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517679545
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.

7-200 Toxic Supplies and Applications

7-201.11A ***** Priority 1 *****

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

GRILL CLEANER FOUND STORED ON SHELF ABOVE CLEAN ITEMS ON 3-COMP DRAIN AREA. INSTRUCTED CHEF TO MOVE CHEMICAL DOWN AND AWAY. CORRECTED ON SITE.

Comply By: 10/03/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

FOOD FOUND STORED ON FLOOR IN WALK-IN FREEZER AND DRY STORAGE.

Comply By: 10/05/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BACK OF SOIL TABLE FOUND WITH BLACK SUBSTANCE ON SILICONE BETWEEN SOIL TABLE AND WALL. CLEAN AND MAINTAIN CLEAN OR REMOVE OLD SILICONE AND REAPPLY.

Comply By: 11/03/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVE ON CHEF'S COUNTER HAS SPLATTERS OF FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 10/04/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Bucket (cook line)
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Bucket (server area)
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Dispenser (3-comp)
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/Chx; Bone in
Temperature: 170 Degrees Fahrenheit - Location: Hot Holding (cook line)
Violation Issued: No

Process/Item: Hot Hold/Aug Potatoes
Temperature: 168 Degrees Fahrenheit - Location: Hot Holding (cook line)
Violation Issued: No

Process/Item: Cold Hold/Salsa
Temperature: 41 Degrees Fahrenheit - Location: Undercounter Cooler (cook line)
Violation Issued: No

Process/Item: Hot Hold/Soup
Temperature: 163 Degrees Fahrenheit - Location: Soup Warmer (server area)
Violation Issued: No

Process/Item: Cold Hold/Salad (to-go)
Temperature: 41 Degrees Fahrenheit - Location: Upright Reach-in (server area)
Violation Issued: No

Process/Item: Cold Hold/Mac Salad
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Type: Full
Date: *10/03/22*
Time: 11:30:00
Report: 1031221154
Lilydale Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/Beef Stew
Temperature: 37 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 40 Degrees Fahrenheit - Location: Milk Cooler (resident foodservice area)
Violation Issued: No

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

Inspection conducted by Chris F, in the presence of Ben Welna.

All violations discussed with Ben and Chef after inspection.

NOTES:

- No foods are undercooked

- Pasteurized eggs in stock and used as needed.

- Gloves utilized for all cooking and serving.

- Cutting boards are being as food contact surfaces.

- Extra care needs to be taken when cleaning under dry storage.

- When preparing food from raw, make sure to use a thermometer to check temperatures.

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

I acknowledge receipt of the Environmental Health inspection report number 1031221154 of 10/03/22.

Certified Food Protection Manager: Visenta Corral

Certification Number: FM77353 Expires: 03/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ben Welna
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031221154

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1	Date	10/03/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Lilydale Senior Living	949 Sibley Memorial Highway	Lilydale, MN	55118	6517679545

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037891		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	IN (OUT)	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/03/22

Inspector (Signature)