Electronically Delivered

December 26, 2025

Licensee
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN 56560

RE: Project Number(s) SL28989016

Dear Licensee:

On November 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN

Electronically Delivered

October 17, 2025

Licensee
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN 56560

RE: Project Number(s) SL28989016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 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.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	R 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ASSISTED LIVING	2615 PARKVIEW DRIVE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28989016-1 On July 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 23, 2025. At the time of the survey, there were 22 residents; 22 receiving services under the Assisted Living Dementia Care License. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with 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; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 480}	Continued From page 1 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (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; (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; (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; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	

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{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.	{0 775}		

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{0 775}	Continued From page 3 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). Findings include: On a facility tour on April 23, 2025, from 10:15 a.m. to 12:15 p.m., with clinical nurse supervisor (CNS)-B, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR SPECIAL LOCKING ARRANGEMENTS There was a controlled egress locking system installed on all exit doors leading out of the dementia care unit to the exterior exit path of the 2615 Parkview Dr building. During the tour it was unable to be verified whether the exit doors released to exit upon activation of the building fire alarm, sprinkler system or loss of power (fail safe) in the 2615 Parkview Dr building. The single station smoke alarms were tested, and the front main exit door released to open upon activation of smoke alarms. It was explained the controlled egress locking system is required to release to exit upon activation of the building fire alarm system, fire	{0 775}		

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{0 775}	Continued From page 4 sprinkler system or loss of power (fail safe). The controlled egress door locking system was not provided with a device capable of deactivating the controlled egress door system hardware to the unlocked position from the nurse station or other approved location within the locked unit of each building. It was explained the controlled egress locking system is required to be provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of a fire or similar emergency. During an interview at on April 23, 2025, at 10:45 a.m., CNS-B, stated the procedures required to operate and unlock the controlled egress door locking systems for both buildings were not included in the Fire Safety and Evacuation Plan (FSEP). It was explained that the procedures required to operate and unlock the controlled egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required to be included in the FSEP in accordance with MSFC in Minnesota Rules Chapter 7511. EXTERIOR MARKED EXIT PATH GATE LOCKS The two locked exterior gates in the marked exit path leading to the public way in the 2615 Parkview Dr building were provided with locking hardware that requires a key to operate to	{0 775}		

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{0 775}	Continued From page 5 release to exit. It was explained the exterior exit gates in the marked exit path are required to operate to release the doors to exit, the same as the exit doors of the building. It was explained the gates shall be readily openable from the interior in the direction of egress travel or be provided with a compliant controlled egress locking system. During the facility tour CNS-B, verified the above listed observations while accompanying on the tour.	{0 775}		
{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 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	{0 780}		

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{0 780}	Continued From page 6 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms with audible alarm inside all sleeping rooms throughout the facility. This had the potential to directly affect all 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). Findings include: SMOKE ALARMS INSIDE SLEEPING ROOMS On a facility tour on April 23, 2025, from 10:15 a.m. to 12:15 p.m., with clinical nurse supervisor (CNS)-B, it was observed that smoke alarms were not installed inside all sleeping rooms providing an audible alarm inside the sleeping room in the 2725 Parkview Drive building. It was explained all sleeping units are required to have smoke alarms with audible alarm inside all sleeping units.	{0 780}		

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{0 780}	Continued From page 7 During the tour CNS-B, stated the smoke detectors tied to the fire alarm system inside the resident sleeping rooms did not provide an audible alarm inside the sleeping room.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep 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 in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	{0 810}		

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{0 810}	Continued From page 8 evacuation. (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. (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 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. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	{01770}	Not reviewed during this survey.	

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{02320}	Continued From page 9	{02320}		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}	Not reviewed during this survey.	
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected	{02410}		

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{02410}	Continued From page 10 during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	{02410}	Not reviewed during this survey.	

Electronically Delivered

May 29, 2025

Licensee
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN 56560

RE: Project Number(s) SL28989016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 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.

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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ASSISTED LIVING	2615 PARKVIEW DRIVE MOORHEAD, MN 56560

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28989016-0 On April 21, 2025, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 22 residents; 22 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. 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with 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; (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; (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; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 485		

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0 485	Continued From page 4 The findings include: During the entrance conference on April 21, 2025, at 9:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On April 21, 2025, at 9:39 a.m., CNS-B stated the licensee had a monthly fee on a meal plan addendum for residents to receive three meals per day. On page five of the licensee's undated Assisted Living Contract, Meal/Food Plan Addendum indicated resident is made available three (3) meals per day and two (2) snacks through the (licensee's name) Meal/Food Plan at an additional cost. The licensee's undated Meal/Food Plan Addendum indicated the resident could be provided three meals per day with the food plan or could select no meal plan through the licensee. Resident assisted living contracts with meal addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On April 21, 2025, at 12:41 p.m., CNS-B stated the licensee only offered residents to opt into receiving three meals per day or no meals at all. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge.	0 485		

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0 485	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all 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). Findings include: On a facility tour on April 23, 2025, from 10:15 a.m. to 12:15 p.m., with clinical nurse supervisor (CNS)-B, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR SPECIAL LOCKING	0 775		

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0 775	Continued From page 6 ARRANGEMENTS There was a controlled egress locking system installed on all exit doors leading out of the dementia care unit to the exterior exit path from the 2725 Parkview Dr building and the main exit door of the 2615 Parkview Drive (Dr) building. During the tour it was unable to be verified whether the main front door released to exit upon activation of the building fire alarm, sprinkler system or loss of power (fail safe) in the 2615 Parkview Dr building. The single station smoke alarms were tested, and the front main exit door released to open upon activation of smoke alarms. It was explained the controlled egress locking system is required to release to exit upon activation of the building fire alarm system, fire sprinkler system or loss of power (fail safe). The controlled egress door locking systems were not provided with a device capable of deactivating the controlled egress door system hardware to the unlocked position from the nurse station or other approved location within the locked unit of each building. It was explained the controlled egress locking system is required to be provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of a fire or similar emergency. During an interview at on April 23, 2025, at 10:45 a.m., CNS-B, stated the procedures required to operate and unlock the controlled egress door	0 775		

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0 775	Continued From page 7 locking systems for both buildings were not included in the Fire Safety and Evacuation Plan (FSEP). It was explained that the procedures required to operate and unlock the controlled egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required to be included in the FSEP in accordance with MSFC in Minnesota Rules Chapter 7511. MARKED EXIT DOOR/ GATE LOCKING The marked exit door leading to the back patio of the 2615 Parkview Dr building was provided with a deadbolt lock requiring a key to operate to exit in the direction of exit travel and was not designed as a compliant controlled egress fail safe door locking arrangement. It was explained marked exit doors shall be readily openable from the direction of exit travel without the use of a key tool or special knowledge or have compliant controlled egress special locking arrangement hardware installed in accordance with MSFC in Minnesota Rules Chapter 7511. The marked exit door leading to the back patio of the 2615 Parkview Dr building was provided with a lock on the door latch, a deadbolt lock and a lock on the storm door latch. This locking arrangement requires three operations before the exit door will release to exit. The door leading to the back patio of the 2725 Parkview Dr building had a magnetic locking device used to lock the door as part of the	0 775		

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0 775	Continued From page 8 controlled egress locking system, a lock on the door latch, and a dead bolt lock not tied into the controlled egress locking system installed on the door. The door latch and deadbolt installed on the door requires a second, and third operation in order for the door to release to open. It was explained that marked exit doors provided with locks shall only require one operation to release the door to exit. EXTERIOR MARKED EXIT PATH GATE LOCKS The exterior gate in the marked exit path leading to the public way of the 2725 Parkview Dr building was provided with locking hardware that requires a key to operate and installed on the non-egress side of the gate. The two locked exterior gates in the marked exit path leading to the public way in the 2615 Parkview Dr building were provided with locking hardware that requires a key to operate to release to exit. It was explained the exterior exit gates in the marked exit path are required to operate to release the doors to exit, the same as the exit doors of the building. It was explained the gates shall be readily openable from the interior in the direction of egress travel or be provided with a compliant controlled egress locking system. SLEEPING UNIT DOOR HANDLE The door handle was removed and there was no handle on the inside to use to open the door in the direction of egress travel from sleeping unit three in the 2725 Parkview Dr building. There was also no way to latch the door closed because	0 775		

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0 775	Continued From page 9 the latch was removed from the door. It was explained all doors are required to be provided with a handle and latch to open from the inside for exiting and to positively latch closed. STORAGE OBSTRUCTIONS There was storage obstructing access to the electrical panels, fire protection equipment, and fire alarm panel in the mechanical room of the 2725 Parkview Dr building. There were items stored in the marked exit path of the second-floor apartment at the bottom of the stairs. It was explained the marked exit paths and area in front and around mechanical and fire protection systems shall be kept clear of storage that obstructs access to the equipment. SMOKE DETECTOR MAINTENANCE There was a plastic dust cap installed on the building fire alarm system smoke detector in the laundry room of the second-floor apartment in the 2725 Parkview Dr building. It was explained the smoke detectors are required to be maintained with dust covers removed in order for detector to operate as designed to detect smoke. FIRE EXTINGUISHER MOUNTING There was a fire extinguisher under the kitchen sink that was sitting on the floor of the cabinet and not mounted in place. It was explained that fire extinguishers are	0 775		

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0 775	Continued From page 10 required to be mounted at least four inches and not more than 60 inches to top of extinguisher from the floor. During the facility tour CNS-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used 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;	0 780		

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0 780	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms with audible alarm inside all sleeping rooms throughout the facility. This had the potential to directly affect all 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). Findings include: SMOKE ALARMS INSIDE SLEEPING ROOMS On a facility tour on April 23, 2025, from 10:15 a.m. to 12:15 p.m., with clinical nurse supervisor (CNS)-B, it was observed that smoke alarms were not installed inside all sleeping rooms providing an audible alarm inside the sleeping rooms in the 2725 Parkview Drive building. It was explained all sleeping units are required to have smoke alarms with audible alarm inside all sleeping units. During the tour CNS-B, stated the smoke detectors tied to the fire alarm system inside the resident sleeping rooms did not provide an audible alarm inside the sleeping room. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 800	Continued From page 12	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep 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 in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on April 23, 2025, from 10:15 a.m. to 12:15 p.m., with clinical nurse supervisor (CNS)-B, the surveyor made the following observations of facility disrepair:	0 800		

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0 800	Continued From page 13 The building ventilation system was not plugged in and operational. It was explained the building ventilation system provides required exhaust for bathrooms and exhaust and ventilation for control of air quality throughout the building in accordance with Minnesota Mechanical Code in Minnesota Rules Chapter 1346. During the facility tour CNS-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ASSISTED LIVING	2615 PARKVIEW DRIVE MOORHEAD, MN 56560

(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
0 810	Continued From page 14 (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 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, provide required training and drills. This had the potential to directly affect all 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 potential to affect a large portion or all of the residents). The findings include: On April 23, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 15 FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on April 23, 2025, at 9:20 a.m., CNS-B, stated resident procedures required in the event of a fire or similar emergency were not included in writing in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by not providing documentation employees received and completed the training as required. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the training was provided to residents as required. During an interview on April 23, 2025, at 9:30 a.m., CNS-B, stated documentation was not available indicating training was completed by employees or provided to residents as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct	0 810		

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0 810	Continued From page 16 evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation fire evacuation drills were completed in May and September of 2024 only and did not indicate which shift the drills were completed. During an interview on April 23, 2025, at 9:30 a.m., CNS-B, stated documentation was not available indicating fire evacuation drills were completed every other month and twice per shift per year and drills were completed in May and September of 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3). 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	01770		

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01770	Continued From page 17 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on April 21, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R3's diagnoses included mild late onset Alzheimer's dementia without behavioral disturbances. R3's service plan dated April 16, 2025, indicated R3 received medication setup one every 14 days by a licensed practical nurse (LPN). R3's prescriber orders dated April 8, 2025, included the following orders: -levothyroxine (for hypothyroidism) 50 micrograms (mcg) daily; -ascorbic acid (supplement) once capsule daily; -vitamin B12 (supplement) one tablet daily; -Mirabegron ER (for bladder) 50 milligrams (mg) daily; -Nexium (for acid reflux) 20 mg daily; -aspirin (for heart health) 81 mg daily; -Areds 2 (for vision) 2 capsules daily; and -zinc (supplement) 25 mg daily. On April 22, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-D removed R3's weekly medication planner (a medication box with designated compartments for days and times) from the locked medication closet. ULP-D stated LPN-A placed R3's medications into R3's weekly medication planner for ULPs to administer.	01770		

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01770	Continued From page 18 R3's Service Recap Summary- Month dated April 2025, indicated R3 received a Medication Setup on April 10, 2025, by LPN-A, however, R3's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, and route of administration. On April 22, 2025, at 10:31 a.m., LPN-A stated LPN-A completed medication setups for a few residents at the facility. LPN-A further stated LPN-A documented the date of medication setups under resident services after LPN-A setup resident medications in a weekly planner per prescriber orders. CNS-B stated the licensee was aware of the documentation requirement for medication setups, however, the licensee had entered medication setups incorrectly into Rtasks (electronic medical record software) to reflect LPN-A's documentation of medication setups. The licensee's Medication Management Services policy dated October 5, 2021, indicated the registered nurse (RN) or LPN will verify that the dose and quantity of medications delivered is consistent with the prescription, review prescribed medications to identify any contraindications or other concerns, identify whether refills are needed and follow up to be sure the refill is available when needed, and verify that medications for the previous period were administered as prescribed. The policy did not address how to document a medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-D) observed administering medications. 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: During the entrance conference on April 21, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing).	02320		

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02320	Continued From page 20 R2's Service Plan dated March 4, 2025, and April 23, 2025, respectively, indicated R2 received medication administration four times per day. R2's prescriber orders dated February 25, 2025, included an order for Wixela Inhub 250-50 micrograms (mcg)/dose inhaler- inhale one puff into the lungs every 12 hours and rinse mouth after use. R2's Med (medication) Admin (administration) Summary-Actual- Month dated April 2025, indicated Wixela Inhub 250-50 mcg- inhale one puff into the lungs every 12 hours and rinse mouth after use. On April 22, 2025, at 7:58 a.m., the surveyor observed ULP-D provide scheduled morning medication administration for R2. ULP-D placed R2's Wixela inhaler up to R2's mouth and R2 inhaled one puff from the Wixela inhaler. Immediately following the inhaler administration, ULP-D administered R2's oral medications, and R2 swallowed the oral medications with water. The surveyor did not observe ULP-D offer R2 water to rinse and spit after inhalation of the Wixela inhaler. On April 22, 2025, at 12:12 p.m., ULP-D stated R2 had never wanted to rinse R2's mouth after administration of the Wixela inhaler and R2 preferred to take R2's oral medications right after the inhaler administration. On April 23, 2025, at 12:22 p.m., CNS-B stated ULPs were trained to bring a small cup of water for residents to swish around and spit out after administration of an inhaler if the electronic medication administration record (EMAR) had instructions to do so. CNS-B further stated a	02320		

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02320	Continued From page 21 resident should have been encouraged by the ULP to rinse their mouth each time after inhaler administration. The manufacturer's instructions for Wixela dated July 2021, indicated to rinse mouth with water after you have used the Wixela inhaler and spit the water out. Do not swallow the water. The licensee's Administration of Medication, Treatment and Therapy by ULP dated December 27, 2022, indicated the registered nurse (RN) must instruct the ULP in the proper methods to administer medications and determine that the ULP has demonstrated the ability to competently follow the procedures. In addition, the RN developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the	02410		

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02410	Continued From page 22 unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of four residents (R2) during medication management services in a nonprivate area. 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: During the entrance conference on April 21, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On April 22, 2025, at 8:06 a.m., the surveyor observed R2 sitting at a dining room table with	02410		

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02410	Continued From page 23 one other resident seated at the same table. The surveyor observed unlicensed personnel (ULP)-D verbalize to R2 the need to apply R2's prescribed Ketoconazole 2% cream and ULP-D proceeded to apply Ketoconazole 2% cream to R2's face. The surveyor did not observe ULP-D offer to move R2 to a private area to apply R2's cream or ask R2 if R2 was okay with having the Ketoconazole 2% cream administered at the dining room table with another resident present. In addition, the surveyor did not observe ULP-D ask the other resident at the dining room table if they were comfortable with having R2's topical cream administered at the dining room table. On April 22, 2025, at 12:12 p.m., ULP-D stated ULP-D had known R2's preference was having all medications, including topical medications, being administered at the dining room table in the morning. On April 23, 2025, at 12:28 p.m., CNS-B stated medication administration location depended on the resident preference indicated in the resident chart, however, non-oral medications were sometimes administered in a resident room. Licensed practical nurse (LPN)-A stated it was expected for the ULPs to ask if the resident wanted to move to a private area prior to topical medication administration. The licensee's Administration of Medication, Treatment and Therapy by ULP dated December 27, 2022, indicated the registered nurse (RN) must instruct the ULP in the proper methods to administer medications and determine that the ULP has demonstrated the ability to competently follow the procedures. In addition, the RN communicated with the ULP about the individual needs of the resident.	02410		

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02410	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *04/23/25*
Time: 11:15:00
Report: 1049251081

Food and Beverage Establishment Inspection Report

Location:
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN56560
Clay County, 14

Establishment Info:
ID #: 0038909
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.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

THE ESTABLISHMENT LACKED TEST STRIPS FOR THEIR 3-COMPARTMENT SINK SANITIZER AND FOR THEIR SANITIZER DISH MACHINES. PIC IS INSTRUCTED TO OBTAIN APPROPRIATE TEST STRIPS FOR BOTH TYPES OF SANITIZER.

Comply By: 04/23/25

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

THE CAN OPENER BLADE HAD FOOD DEBRIS ACCUMULATION. PIC IS INSTRUCTED TO CLEAN THE CAN OPENER ON A REGULAR BASIS TO PRECLUDE FOOD DEBRIS ACCUMULATION.

Comply By: 04/23/25

2-100 Supervision

2-102.12AMN

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

HOLLY HEISER TOOK A FOOD SAFETY COURSE, HOWEVER, THE PIC IS INSTRUCTED TO SUBMIT THE INITIAL APPLICATION TO THE STATE TO RECEIVE THE CFPM CERTIFICATE TO POST AT THE ESTABLISHMENT.

Comply By: 04/23/25

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.

IN THE DRY STORAGE ROOM, THERE WAS A BAG OF JASMINE RICE AND A BOX OF CHIPS ON THE FLOOR. PIC RELOCATED THE FOOD AT LEAST 6 INCHES ABOVE THE FLOOR. VIOLATION CORRECTED ON SITE.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11AMN

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

THE DOMESTIC CROCKPOT IN THE PREP/COOKING KITCHEN IS FOR HOUSEHOLD USE ONLY. PIC INSTRUCTED TO REPLACE THE CROCKPOT WITH COMMERCIAL ANSI EQUIPMENT.

Comply By: 04/23/25

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

THERE WAS A BOX OF PLASTIC FORKS AND SMALL BAGS ON THE FLOOR IN THE KITCHEN. IN THE STORAGE ROOM, THERE WAS A BOX OF CUPS AND COOKING EQUIPMENT ON THE FLOOR. PIC RELOCATED ALL ITEMS AT LEAST 6 INCHES ABOVE THE FLOOR. VIOLATION COS.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: Kitchen 1 Dish Machine
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: Kitchen 2 Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *04/23/25*
Time: 11:15:00
Report: 1049251081
Lilac Homes Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 213.5 Degrees Fahrenheit - Location: Pork Chops
Violation Issued: No

Process/Item: Cooking
Temperature: 184.5 Degrees Fahrenheit - Location: Green Beans
Violation Issued: No

Process/Item: Cooking
Temperature: 163.5 Degrees Fahrenheit - Location: Potatoes
Violation Issued: No

Process/Item: Upright Cooler 1
Temperature: 37.5 Degrees Fahrenheit - Location: Cottage Cheese
Violation Issued: No

Process/Item: Upright Cooler 1
Temperature: 37.5 Degrees Fahrenheit - Location: Strawberry Topping
Violation Issued: No

Process/Item: Upright Cooler 2
Temperature: 37 Degrees Fahrenheit - Location: Orange Juice
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	4

INSPECTOR MET WITH MDH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

THE COOKING/PREP KITCHEN HAD A PAINTED CEILING, FRP WALLS, TILE FLOORING AND STAINLESS STEEL CABINETS.

THE SECOND KITCHEN HAD A PAINTED CEILING, PAINTED WALLS, TILE FLOORING, LAMINATE COUNTERTOPS AND WOOD CABINETS.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: *04/23/25*
Time: 11:15:00
Report: 1049251081
Lilac Homes Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1049251081 of 04/23/25.

Certified Food Protection Manager: NEED

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: *Stephanie Reynolds*

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
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