DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 20, 2022

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

RE: Project Number(s) SL34812015

Dear Administrator:

On September 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 7, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

Electronically Delivered

August 1, 2022

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

RE: Project Number(s) SL34812015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 7, 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 - 0250 - 144g.20 Subdivision 1 - Conditions = $3,000
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services =$3,000

The total amount you are assessed is $6,500. 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,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** 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: SL34812015 On, July 5, 2022, through July 7, 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 32 residents, all of whom received services under the provider's Assisted Living Dementia Care license. An immediate correction order was identified on July 6, 2022, issued for SL34812015, tag identification 2310. On July 7, 2022, the immediacy of the correction order 2310 was removed, however, non-compliance remained at a patterned scope, level three (H).	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 250 SS=H	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 5, 2022, at 10:20 a.m., licensed practical nurse (LPN)-B	0 250		

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0 250	Continued From page 3 and general manager (GM)-K stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

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0 250	Continued From page 4	0 250		

may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-C on May 13, 2021. The licensee had an assisted living license with dementia care issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - conducting a TB risk assessment consistent with current United States Centers for Disease Control and Prevention standards; and - treatment management On July 7, 2022, at 10:57 a.m., registered nurse (RN)-A stated I know I'm not up on all the new regulations. I'm just trying my best. As a result of this survey, the following orders were issued 0450, 0470, 0510, 0550, 0660, 0800, 0810, 0910, 0920, 0930, 0950, 0970, 1290, 1470,	0 250		

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0 250	Continued From page 6 1540, 1890, 1950, 1960, 2110, 2310, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 450 SS=E	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for five of five residents (R2, R4, R7, R9, R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 450		

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0 450	Continued From page 7 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility lacked to provide person-centered care with regards to sleep and awake preferences for R2, R4, R7, R9 and R10. R2 R2's diagnoses included dementia, diabetes, hypertension, anxiety, paranoia, and weakness. R2's service plan dated May 2, 2022, indicated services included: assistance with dressing, grooming, bathing, toileting, and transfers. R2's assessment dated May 12, 2022, indicated R2 required assistance with bathing, brushing her teeth, combing her hair, needed full assistance with getting dressed, and required assistance of one with transfers. Under the "Rest/Sleep" category of the assessment it was documented R2's typical/preferred rising time was 7:00 a.m. On July 7, 2022, at 5:07 a.m., the surveyor entered R2's unit and asked unlicensed personnel (ULP)-F what time she would be assisting R2 with morning cares. ULP-F stated R2 was already up for the morning. ULP-F stated she starts getting the assigned residents on her unit up around 5:00 a.m. ULP-F stated she provided morning cares for R2 which included washing her up and getting her dressed. ULP-F stated R2 was now seated in her recliner in her room.	0 450		

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0 450	Continued From page 8 On July 7, 2022, at 5:11 a.m., the surveyor knocked on R2's door and requested to enter. The surveyor observed R2 to be seated in her chair fully dressed. R2 immediately stated, "why am I up so early". The surveyor asked R2 if she would have preferred to sleep in a bit later and R2 responded "Yes - this is so early" and R2 closed her eyes and laid her head back on her chair. R4 R4's diagnosis included diabetes, hypertension, atrial fibrillation (irregular often fast heart rate), and congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs). R4's service plan dated October 30, 2021, indicated services included: assistance with dressing, grooming, and bathing. R4's assessment dated May 25, 2022, indicated R4 required assistance with bathing, dressing, brushing teeth, combing her hair and assistance with transferring when needed. Under the "Rest/Sleep" category of the assessment it was documented R2 sometimes gets up at night and wants a snack. No sleep/awake preference was noted. On July 6, 2022, at 6:38 a.m., the surveyor observed R4 to be fully dressed, awake, and seated on the side of her bed. On July 7, 2022, at 6:34 a.m., the surveyor observed R4 to be fully dressed, laying on her bed. On July 7, 2022, at 6:34 a.m. the surveyor attempted to interview R4, R4 just closed her eyes.	0 450		

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0 450	Continued From page 9 R7 R7's diagnoses included cerebrovascular accident (stroke), cognitive deficit, anxiety, and depression. R7's service plan dated October 29, 2020, indicated services included: assistance with bathing, dressing, grooming, toileting and transferring. R7's assessment dated April 21, 2022, indicated R7 required full assistance with bathing, dressing, grooming, feeding, and transferring. Under the "Rest/Sleep" category of the assessment it was documented R7 takes short naps throughout the day and most of the times she sleeps well through the night. Under the speech category it was noted R7 had lost her ability to express speech due to her stroke. On July 7, 2022, at 5:00 a.m., the surveyor observed R7 to be seated in a tilt back wheelchair right outside of the nursing station. The surveyor observed R7 to be sleeping in her pajamas. At 5:16 a.m., the surveyor observed ULP-G and ULP-H to escort R7 back to her room and transfer R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability), gave R7 a partial bath, provided peri-care, and dressed R7. ULP-G and ULP-H then transferred R7 back to her wheelchair using a sit to stand lift and left her positioned in front of her television. R9 R9's diagnoses included dementia, depression, hypertension and chronic fatigue. R9's service plan dated June 7, 2022, indicated	0 450		

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(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
0 450	Continued From page 10 services included: assistance with bathing, dressing, grooming, toileting, and transferring. R9's assessment dated April 22, 2022, indicated R9 required assistance with bathing, dressing, toileting, and grooming. Under the "Rest/Sleep" category of the assessment it was documented R9 likes to get up early (no preference to rise time noted). On July 7, 2022, at 5:45 a.m., the surveyor observed ULP-G and ULP-H to enter R9's room, call out R9's name and turn the lights on in the room. The surveyor observed R9 to remain in bed with his eyes closed. ULP-G and ULP-H called out R9's name several times and touched R9's shoulder. R9 woke up and ULP-G and ULP-H proceeded to provide incontinence care; wash R9's face, hands, and back; apply lotion to his arms and back; dressed R9 and assisted R9 from the side of his bed to his wheelchair. ULP-G escorted R9 out to the common area and positioned R9 in his wheelchair in front of the television. The surveyor attempted to interview R9, however R9 was unable to articulate his sleep/wake preferences. At 6:22 a.m. the surveyor observed R9 to be seated in his wheelchair in the common area in front of the television with his eyes closed and head turned down with his chin towards his chest. R10 R10's diagnoses included diabetes, muscle weakness, dysphagia (difficulty swallowing), and cerebral infarction (stroke). R10's service plan dated May 24, 2022, indicated services included: assistance with bathing, dressing, grooming, toileting and transferring.	0 450		

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

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0 450	Continued From page 11 R10's assessment dated June 22, 2022, indicated R9 received assistance with bathing, dressing, hygiene and transferring. Under the "Rest/Sleep" category of the assessment it was documented R9 states he usually gets dressed around 6:00 a.m. R9 is usually awake and ready for the day before 7:00 a.m. On July 7, 2022, at 6:09 a.m., ULP-F stated she had already provided morning cares for R10 which included, grooming, and getting R10 dressed. At 6:11 a.m., the surveyor observed R10 fully dressed seated in his chair in his room. Upon interview with the surveyor, R10 stated they have a schedule and must get 16 other people ready in the morning - I guess I'm one of the ones on the list that they get up early. The surveyor asked R10 if he would prefer to sleep in a bit later and R10 responded "well yeah". On July 6, 2022, at approximately 6:40 a.m., ULP-H stated each unit has a list of residents that we are expected to get up in the morning before the day shift arrives (7:00 a.m.). ULP-H stated they get the residents up, provide morning cares, get them dressed and then if the resident is still tired, they we put them back to bed. ULP-H stated the night staff start getting residents up around 5:00 a.m. On July 6, 2022, at 9:08 a.m., the surveyor reviewed the communication books on each unit with licensed practical nurse (LPN)-B. LPN-B confirmed there were 10 residents on the list (six residents on the memory care unit and four residents on the enhanced care unit) that had been designated for the night staff to get up and assist with morning cares before the day shift arrives. R2, R4, R7, R9, and R10 were on this list.	0 450		

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0 450	Continued From page 12 On July 7, 2022, at 11:09 a.m., the surveyor asked registered nurse (RN)-A to define person centered care. RN-A responded that person centered care is looking at the resident's individual cares and preferences, likes and interests and then we tailor these to each resident when we provide their care and services. RN-A provided the example if a resident wants to sleep later, than we let them sleep later. RN-A stated the residents are asked upon admission their preferences or patterns of sleep and awake times, however, RN-A stated she does not continue to reassess them with the ongoing reassessments. RN-A stated that the list of residents was created to assist the day staff with morning resident cares and should be based on the resident's preferred schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 13 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 32 residents. 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: The licensee held an Assisted Living with Dementia Care license. The facility was licensed for a capacity of 32 residents and had a current census of 32 residents.	0 470		

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0 470	Continued From page 14 During the entrance conference on July 5, 2022, at 10:20 a.m., licensed practical nurse (LPN)-B and general manager (GM)-K stated the usual staffing schedule for the facility was as follows: - the RN was on call 24/7 and was onsite at varied times three to four days a week - the LPN worked Monday - Thursday from approximately 8:00 a.m. until 6:00 p.m. - the day shift was staffed with two unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m.; one ULP from 7:00 a.m. to 1:00 p.m. and, one ULP from 7:00 a.m. to 11:00 a.m. - the evening shift was staffed with two ULP from 3:00 p.m. to 11:00 p.m., one ULP from 5:00 p.m. to 9:00 p.m. and, one ULP from 6:00 p.m. to 10:00 p.m. - the night shift was staff with three ULP from 11:00 p.m. to 7:00 p.m. On July 5, 2022, at 11:12 a.m., the surveyor asked to see the facility's staffing plan. The surveyor was provided a template Long-Term Care Contingency Staffing Plan dated July 24, 2020. On July 7, 2022, at 11:24 a.m., registered nurse (RN)-A stated she had not developed a staffing plan for the facility besides working through the contingency staffing plan noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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	0 510		

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0 510	Continued From page 15 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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). This had the potential to affect all 32 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: The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers working with residents with or without suspected	0 510		

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0 510	Continued From page 16	0 510		

or confirmed SARS-CoV-2 (Covid-19) wear a face mask and eye protection in communities with substantial and high community transmission levels.

On July 5, 2022, at 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct a blood glucose check and administer R1's scheduled insulin. At 11:55 a.m., the surveyor observed ULP-D to transfer R1 from her recliner to a wheelchair using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). At 12:04 p.m., the surveyor observed ULP-D to conduct a blood glucose check and administer R2's scheduled insulin. The surveyor observed ULP-D to be wearing a surgical grade mask, but no eye protection.

On July 5, 2022, at 12:58 p.m., the surveyor observed ULP-E administer R4's scheduled medications. The surveyor observed ULP-E to be wearing a surgical grade mask, but no eye protection.

On July 6, 2022, at 7:35 a.m., the surveyor observed ULP-J conduct a blood glucose check and administer R4's scheduled morning medications. The surveyor observed ULP-J to be wearing a surgical grade mask, but no eye protection.

On July 6, 2022, at 8:07 a.m., the surveyor observed ULP-I administer R1's scheduled medications which included oral medications and eye drops. The surveyor observed ULP-I to be wearing a surgical mask, but no eye protection.

On July 7, 2022, at 5:16 a.m., the surveyor observed ULP-G and ULP-H to transfer R7 from

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0 510	Continued From page 17 her wheelchair to the toilet and back to the wheelchair using a sit to stand lift. At 5:45 a.m. the surveyor observed ULP-G and ULP-H to provide morning cares which included partial bed bath, incontinence care and dressing for R9. The surveyor observed ULP-G and ULP-H to be wearing surgical masks, but no eye protection. On July 7, 2022, at 11:00 a.m., registered nurse (RN)-A stated the facility tries to follow the CDC guidelines with regards to PPE usage. RN-A stated the staff are directed to wear eye protection if we have an outbreak at the facility. RN-A was not familiar with the PPE Grid referenced above. RN-A reviewed with the surveyor the facility's county transmission level on the computer. RN-A stated the current county transmission level was high, so according to the PPE Grid staff should be wearing eye protection when working with residents with or without suspected or confirmed COVID-19. The licensee's COVID-19 PPE Guidelines for Infection Control dated October 13, 2021, noted if active cases of COVID-19 are present, the following use of PPE will be utilized until there are 14 consecutive days with no new positive results. All staff will wear eye protection which covers the side and top of the eyes while on the assisted living unit or memory care unit. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 18 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current 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 July 5, 2022, at 12:15 p.m., the surveyor toured the facility with registered nurse (RN)-A, the main entrance and/or common areas lacked the required posting for the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances and; the contact information for the state and applicable regional Office of Ombudsman for	0 550		

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0 550	Continued From page 19 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 5, 2022, at 12:19 p.m., RN-A stated what was posted in the main entrance was a generic grievance procedure for the facility and confirmed it did not include the above noted required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention	0 660		

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0 660	Continued From page 20	0 660		

program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment.

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:

During the entrance conference on July 5, 2022, at 11:12 a.m., the surveyor asked for the licensee's facility TB risk assessment, which was provided and later reviewed by the surveyor.

The licensee's facility TB risk assessment had been completed by registered nurse (RN)-A and was dated November 18, 2019. The facility had been identified as low risk.

On July 5, 2022, at 3:33 p.m., RN-A stated the facility's TB risk assessment should be completed every two years as we are low risk. RN-A stated "I'm late" as it has been over two years since it has been completed.

The licensee's TB Prevention and Control policy dated October 13, 2021, noted the RN was responsible for completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health. A review and revision of the TB risk assessment would occur every two years.

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0 660	Continued From page 21 The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
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 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) and was issued at a	0 800		

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0 800	Continued From page 22 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 residents). The findings include: On July 5, 2022, from 1:45 p.m. to 3:30 p.m., survey staff toured the facility with owner (O)-C. During the facility tour, survey staff observed and verified the gate for the courtyard is locked limiting a means of egress during a fire or similar emergency from inside the courtyard. This was evident as the facility had three identified exit doors inside the building and the facility's evacuation plan both directed to exit into the locked courtyard. On July 5, 2022, at approximately 3:30 p.m., O-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 23 (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 observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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 the potential to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 24 affect a large portion or all residents). The findings include: On July 5, 2022, from approximately 1:45 p.m. to 3:30 p.m., survey staff toured the facility with owner (O)-C. During the facility tour, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following. 1. Documentation of required employee evacuation drills did not show drills being done every other month. 2. The schedule and required records on training of employees on fire safety and evacuation. 3. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, and relocation. On July 5, 2022, at approximately 3:30 p.m. O-C was not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910		

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(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
0 910	Continued From page 25 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R4) with records reviewed. This had the potential to affect all 32 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's Service Plan dated June 30, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings, wound care and assistance with toileting, bathing, dressing, grooming, housekeeping and laundry. R1's Housing with Services Contract and Lease Agreement (assisted living contract), signed by R1's legal representative and dated September 23, 2021, lacked the license number of the facility.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ENHANCED ASSISTED LIVING I	1500 SOUTHWOOD DRIVE DILWORTH, MN 56529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 26 R2 R2's Service Plan dated May 2, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R2's Housing with Services Contract and Lease Agreement signed by R2's legal representative and dated May 2, 2022, lacked the license number of the facility. R4 R4's Service Plan dated December 21, 2021, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R4's Housing with Services Contract and Lease Agreement, signed by R4's legal representative and dated October 29, 2021, lacked the license number of the facility. On July 7, 2022, at 10:22 a.m., registered nurse (RN)-A stated the facility was currently using the same template assisted living contract noted above for all residents. RN-A reviewed the contract and stated the licensee number was currently not identified on the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 27	0 920		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R4) with records reviewed. This had the potential to affect all 32 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	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 28 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's Service Plan dated June 30, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings, wound care and assistance with toileting, bathing, dressing, grooming, housekeeping and laundry. R2 R2's Service Plan dated May 2, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R4 R4's Service Plan dated December 21, 2021, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R1, R2 and R4's Housing with Services Contract and Lease Agreement (assisted living contract) dated September 23, 2021, May 2, 2022, and October 29, 2021, respectively lacked a disclosure of the category of assisted living facility license held by the facility and a disclosure of the facility's ability to provide specialized diets. On July 7, 2022, at 10:22 a.m., registered nurse (RN)-A stated the facility was currently using the	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 29 same template assisted living contract noted above for all residents. RN-A reviewed the contract and stated this is an older contract and we have an attorney drafting a new contract for us. At 10:24 a.m., RN-A confirmed the above required information was not included in the resident's current assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced	0 930		

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0 930	Continued From page 30 by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R4) with records reviewed. This had the potential to affect all 32 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's Service Plan dated June 30, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings, wound care and assistance with toileting, bathing, dressing, grooming, housekeeping and laundry. R2 R2's Service Plan dated May 2, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R4 R4's Service Plan dated December 21, 2021, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry.	0 930		

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0 930	Continued From page 31 R1, R2 and R4's Housing with Services Contract and Lease Agreement (assisted living contract) dated September 23, 2021, May 2, 2022, and October 29, 2021, respectively lacked the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. On July 7, 2022, at 10:22 a.m., registered nurse (RN)-A stated the facility was currently using the same template assisted living contract noted above for all residents. RN-A reviewed the contract and stated this is an older contract and we have an attorney drafting a new contract for us. At 10:27 a.m., RN-A confirmed the above required information was not included in the resident's current assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 32 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of three residents (R1, R2, R4) with records reviewed. This had the potential to affect all 32 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 the potential to affect a large portion or all the residents). The findings include:	0 950		

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0 950	Continued From page 33 R1 R1's Service Plan dated June 30, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings, wound care and assistance with toileting, bathing, dressing, grooming, housekeeping and laundry. R2 R2's Service Plan dated May 2, 2022, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R4 R4's Service Plan dated December 21, 2021, indicated services included: medication management, blood glucose monitoring, compression stockings and assistance with bathing, grooming, housekeeping and laundry. R1, R2, and R4's record lacked evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that R1, R2 and R4 declined to name a designated representative. On July 7, 2022, at 10:32 a.m., registered nurse (RN)-A stated she was not up to speed with all the new assisted living regulations and stated we are not meeting this requirement for the residents to identify or decline to name a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 34	0 970		
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. 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 the potential to affect a large portion or all the residents). The findings include: On July 5, 2022, at 11:12 a.m., during the entrance conference, the surveyor asked for a copy of the facility's assisted living contract. The facility's Housing with Services Contract and Lease Agreement (assisted living contract) included two clauses that indicated the resident	0 970		

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0 970	Continued From page 35	0 970		

would waive the facility's liability for health, safety, or personal property of the resident. Page 10, section 24, Indemnification of the assisted living contract indicated the "Tenant will indemnify and hold harmless Landlord, its employees 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 the use by Tenant of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Tenant or Tenant's guests or agents." Section 26, Liability of the assisted living contract indicated the "Landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Apartment Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Tenant or Tenant's guests." This section of the contract went on to read "Landlord may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons. Tenant agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Landlord's premises."

On July 7, 2022, at 10:22 a.m., registered nurse (RN)-A stated the facility was currently using the same template assisted living contract noted above for all residents. RN-A reviewed the contract and stated this is an older contract and we have an attorney drafting a new contract for us. RN-A stated she could see how this language could be interpreted in a way that did not meet the regulation.

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0 970	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living with dementia care license for two of three employees (unlicensed personnel/ULP-D, ULP-G), with records reviewed. 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	01290		

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01290	Continued From page 37	01290		

pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ULP-D
ULP-D was hired on November 30, 2021, to provide direct care services to the licensee's residents.

On July 5, 2022, at 11:45 a.m., the surveyor observed ULP-D conduct a blood glucose check and administer R1's scheduled insulin. At 11:55 a.m., the surveyor observed ULP-D to transfer R1 from her recliner to a wheelchair using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). At 12:04 p.m., the surveyor observed ULP-D to conduct a blood glucose check and administer R2's scheduled insulin.

ULP-D's employee record contained a background study, submitted by a separate location operated by the licensee dated April 22, 2022. ULP's employee record lacked evidence the licensee submitted a background study for their license.

ULP-G
ULP-G was hired on June 30, 2021, to provide direct care services to the licensee's residents.

On July 7, 2022, at 5:16 a.m., the surveyor observed ULP-G and ULP-H to transfer R7 from her wheelchair to the toilet and back to the wheelchair using a sit to stand lift. At 5:45 a.m. the surveyor observed ULP-G and ULP-H to

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

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01290	Continued From page 38 provide morning cares which included partial bed bath, incontinence care and dressing for R9. ULP-G's employee record contained a background study, submitted by a separate location operated by the licensee dated April 6, 2022. ULP's employee record lacked evidence the licensee submitted a background study for their license. On July 7, 2022, at 12:57 p.m., registered nurse (RN)-A and general manager (GM)-K stated the background studies for ULP-D and ULP-G were submitted under their other assisted living facility in a nearby town. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 39 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content was completed for two of three employees (licensed practical nurse/LPN-B, unlicensed personnel/ULP-G) with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-B LPN-B was hired on June 15, 2021, to provide direct care services to residents at the assisted living with dementia care facility. LPN-B's employee records lacked the following required orientation content: - an overview of the 144G statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 41 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-G ULP-G was hired on June 30, 2021, to provide direct care services to the licensee's residents. On July 7, 2022, at 5:16 a.m., the surveyor observed ULP-G and ULP-H to transfer R7 from her wheelchair to the toilet and back to the wheelchair using a sit to stand lift. At 5:45 a.m., the surveyor observed ULP-G and ULP-H to provide morning cares which included partial bed bath, incontinence care and dressing for R9. ULP-G's employee records lacked the following required orientation content: - an overview of the 144G statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 42 Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On July 7, 2022, at 1:08 p.m., general manager (GM)-K stated she had reviewed LPN-B and ULP-G's transcript and she stated LPN-B and ULP-G had not completed the above noted orientation as required. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated August 26, 2021, noted ULP shall meet all required orientation and screening requirements prior to providing any services to an assisted living resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01540		

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01540	Continued From page 43	01540		

and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel/ULP-D, ULP-G) received the required amount of dementia care training in the required time frame with records reviewed.

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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ULP-D
ULP-D was hired on November 30, 2021, to provide direct care services to the licensee's residents.

On July 5, 2022, at 11:45 a.m., the surveyor observed ULP-D conduct a blood glucose check and administer R1's scheduled insulin. At 11:55 a.m., the surveyor observed ULP-D to transfer R1 from her recliner to a wheelchair using a sit to

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01540	Continued From page 44 stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). At 12:04 p.m., the surveyor observed ULP-D to conduct a blood glucose check and administer R2's scheduled insulin. ULP-D's employee records did not indicate a total of 8 hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-D's employee record indicated the employee had completed 4.75 hours of dementia training. ULP-G ULP-G was hired on June 30, 2021, to provide direct care services to the licensee's residents. On July 7, 2022, at 5:16 a.m., the surveyor observed ULP-G and ULP-H to transfer R7 from her wheelchair to the toilet and back to the wheelchair using a sit to stand lift. At 5:45 a.m. the surveyor observed ULP-G and ULP-H to provide morning cares which included partial bed bath, incontinence care and dressing for R9. ULP-G's employee records did not indicate a total of 8 hours of the required initial dementia training was completed within 80 hours of the employee's start date. ULP-G's employee record indicated the employee had completed 2 hours of initial dementia care training. On July 7, 2022, at 1:04 p.m., general manager (GM)-K stated she had reviewed ULP-D and ULP-G's transcript and she stated ULP-D and ULP-G had not completed the required 8 hours of dementia care training as required. Registered nurse (RN)-A stated both ULP had worked greater than 80 hours since their start dates.	01540		

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01540	Continued From page 45 The licensee's Dementia Program Disclosure Requirements policy dated August 31, 2021, noted the licensee provided a specialized memory care program for their residents. They provide the required dementia care training to all their direct care staff and the supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01890 SS=D	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: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for one of three residents (R3) with records reviewed. 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 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).	01890		

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01890	Continued From page 46 The findings include: On July 5, 2022, at 11:20 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-B, including a review of the locked medication cupboards. LPN-B observed and confirmed the following: R3's Breo Ellipta 100 micrograms (mcg)/25 mcg inhaler (corticosteroid) did not have a label which indicated the date the inhaler had been removed from the pouch and when the inhaler would expire. R3's Incruse Ellipta 62.5 mcg (inhaler that works by relaxing muscles in the airways to improve breathing) did not have a label which indicated the date the inhaler had been removed from the foil tray and when the inhaler would expire. On July 5, 2022, directly following the above noted observation, LPN-B stated she was unaware that some inhalers needed to be dated when opened. LPN-B and the surveyor reviewed the labels on R3's Breo Ellipta and Incruse Ellipta inhalers and LPN-B stated the directions on both inhalers indicated the inhalers needed to be discarded six weeks after opening. The manufacturer's instructions for the use for the use of the Breo Ellipta inhaler dated May 2017, directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. Write the 'tray opened" and "discard" dates on the inhaler label. The manufacturer's instructions for the use of the Incruse Ellipta inhaler dated June 2019, directed for the inhaler to be discarded six weeks after it	01890		

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01890	Continued From page 47 had been opened from the foil tray. Write the "tray opened" and "discard" dates on the inhaler label. The licensee's Storage of Medications policy dated October 5, 2021, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the expiration date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01950		

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01950	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure instructions, specified in writing, for each resident and documented those instructions in the resident's record for one of three residents (R4) who received blood glucose monitoring. 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: R4's diagnosis included diabetes, hypertension, atrial fibrillation (irregular often fast heart rate), and congested heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs). On July 6, 2022, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-J to conduct a blood glucose monitoring check on R4 which resulted in a reading of 126 milligrams (mg)/deciliter (dL). R4's prescriber orders dated November 1, 2021, included an order for blood glucose monitoring twice daily. R4's Service Plan dated December 21, 2021, and R4's Individualized Treatment and Therapy Plan dated June 28, 2022, indicated R4 needed	01950		

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01950	Continued From page 49 assistance with blood glucose monitoring twice daily. R4's Medication Administration Record (MAR) dated June 1, 2022, through July 6, 2022, directed for blood glucose checks to be completed two times a day (8:00 a.m. and 8:00 p.m.). R4's blood glucose monitoring report dated June 6, 2022, through July 6, 2022, indicated blood glucose checks had been completed twice daily with results ranging from 116 to 282 mg/dL. R4's record lacked specific written instructions for twice daily blood glucose monitoring to include parameters for evaluation of results. On July 7, 2022, at 10:48 a.m., registered nurse (RN)-A stated R4's record did not include specific instructions with regards to blood glucose monitoring parameters and instructions of when the ULP would notify the RN. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated October 5, 2021, indicated the treatment order must contain information needed to administer the treatment or therapy and any parameter or instructions to hold or modify the therapy if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 50	01960		

assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of three residents (R2) with blood glucose monitoring managed by the provider.

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 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:

R2's diagnoses included dementia, diabetes, hypertension, anxiety, paranoia, and weakness.

R2's service plan and Individualized Treatment and Therapy Plan dated May 2, 2022, indicated R2 received blood glucose monitoring checks three times a day.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 51 On July 5, 2022, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-D conduct a blood glucose monitoring check on R2 which resulted in a reading of 243 milligrams (mg)/deciliter (dL). R2's prescriber orders dated May 4, 2022, included an order for blood glucose monitoring three times daily. R2's electronic record directed staff to notify the nurse if R2's blood glucose results were less than 100 mg/dL or greater than 300 mg/dL. R2's Medication Administration Record (MAR) dated June 1, 2022, through July 6, 2022, directed for blood glucose checks to be completed three times daily (8:00 a.m., 12:00 p.m., and 5:00 p.m.). R2's blood glucose monitoring report dated June 6, 2022, through July 6, 2022, indicated blood glucose checks had been completed three times daily. The following dates/times resulted in a blood glucose level less than 100 mg/dL: - June 7, 2022, at 5:00 p.m. with a blood glucose result of 78 mg/dL - June 8, 2022, at 5:00 p.m. with a blood glucose result of 96 mg/dL - June 18, 2022, at 12:00 p.m. with a blood glucose result of 68 mg/dL - June 28, 2022, at 5:00 p.m. with a blood glucose result of 98 mg/dL R2's record lacked evidence that the nurse had been notified of the low blood glucose results on June 7, 2022; June 8, 2022; and June 28, 2022. On July 7, 2022, at 10:39 a.m., licensed practical nurse (LPN)-B stated the staff should be notifying	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 52 the nurse when R2's blood glucose levels are less than 100 mg/dL. LPN-B reviewed R2's electronic record and stated the above noted dates/times had not been reported to the nurse as directed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged;	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 53 (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia 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, 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. On July 5, 2022, at 11:12 a.m., during the entrance conference, the surveyor asked for the licensee's assisted living with dementia care policies and procedures. The policies and procedures provided did not include the following: - Evaluation of behavioral symptoms and design of supports for intervention plans, including	02110		

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	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 54 nonpharmacological practices that are person-centered and evidence-informed; - Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - Limiting the use of public address and intercom systems for emergencies and evacuation drills only; - Transportation coordination and assistance to and from outside medical appointments; and - Safekeeping of residents' possessions. On July 7, 2022, at 10:57 a.m., registered nurse (RN)-A stated I know we don't have all the required dementia care policies and procedures developed. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=H	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R4) with bedrails. In addition, the licensee failed to ensure safe storage of oxygen.	02310	On July 7, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three pattern scope.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

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02310	Continued From page 55	02310		

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

This resulted in an immediate correction order on July 6, 2022, at 12:45 p.m.

The findings include:

R1
On July 6, 2022, at 8:07 a.m., the surveyor observed R1 seated in a wheelchair by the sink in her bathroom. R1's hospital bed had bilateral bedrails secured to the bed and in the upright position.

R1's diagnoses included mild cognitive impairment, localized edema, obesity, diabetes and insomnia.

R1's service plan dated June 30, 2022, indicated the resident received the following services; medication management, assistance with transferring and toileting, bathing, dressing and blood glucose monitoring.

R1's assessment dated June 16, 2022, indicated under the "Bed Safety" portion of the assessment that R1 used upper partial bedrails on her bed to aide in repositioning. The bedrails did not meet FDA guidelines. In addition, the FDA Bed Rail Safety brochure had been provided to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34812	A. BUILDING: _____ B. WING _____	07/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 56	02310		

resident's responsible party to educate them on the risks and benefits of bedrails.

R1's record lacked a bedrail assessment which included actual measurements of the entrapment zones.

On July 6, 2022, at 11:18 a.m., registered nurse (RN)-A measured R1's bedrail with the surveyor present. Zone 1 measured 4 inches wide and 11 inches tall, which is compliant with the FDA guidelines. RN-A stated hospice must have brought in a different bed for her as this bed and bedrail was different than the one she had assessed on June 16, 2022. Pressure was placed on the bedrail and the bedrail appeared to be securely fastened to the bed.

R4
On July 6, 2022, at 6:38 a.m., the surveyor observed R4 seated on the side of her hospital bed. R4 had bilateral bedrails on her bed in the down position.

R4's diagnoses included, dementia, atrial fibrillation (irregular often fast heart rate), diabetes, hypertension, and congested heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should).

R4's Service Plan dated December 21, 2021, indicated the resident received the following services; medication management, incontinence care, blood glucose monitoring, and assistance with bathing, dressing, and grooming.

R4's assessment dated May 25, 2022, indicated under the "Bed Safety" portion of the assessment that R4 used upper partial bedrails on her bed to aide in repositioning and transferring in and out of

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02310	Continued From page 57	02310		

bed. The bedrails did meet FDA guidelines. In addition, education had been provided to the resident's responsible party of the risks and benefits of bedrails.

On July 6, 2022, at 11:05 a.m., RN-A stated bedrails are assessed every 90 days. The assessment includes measurement of the bedrails and then we determine if they meet or don't meet FDA guidelines. RN-A stated the actual measurements of the zones were not documented in R1 and R4's record.

On July 6, 2022, at 11:22 a.m., RN-A measured R4's bedrail with the surveyor present. Zone 1 measured 9 ½ inches wide and 2 ½ inches tall, which is compliant with the FDA guidelines. When RN-A moved the bedrail into the upright position on the left side of the bed, the bedrail appeared to be very loose. RN-A stated the bedrail was very loose and wobbly. RN-A stated we always have trouble with this hospital bed company as the bedrails are often loose. Licensed practical nurse (LPN)-B attempted to position the bedrail on the right side of the bed into the upright position. The right bedrail came right off of the bed and LPN-B struggled to secure the bedrail back on to the bed.

The licensee's Assessing the Safety of Side Rails policy dated December 23, 2019, noted when notified that a resident has a side rail, the RN will assess and evaluate what the client's needs are and assess to determine if the client can safety utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 58	02310		

indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.

The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".

OXYGEN STORAGE
On July 6, 2022, at 6:38 a.m., the surveyor observed in R4's room two oxygen cylinders. One oxygen cylinder was secured in a movable metal stand. The other oxygen cylinder was positioned directly on the floor in an upright position behind the oxygen concentrator. This oxygen cylinder was not securely stored in a holder or stand.

On July 6, 2022, at 9:07 a.m., LPN-B entered R4's room with the surveyor present. LPN-B stated hospice must have brought in the oxygen tanks and they should both be securely stored in a holder. LPN-B stated she would contact the supplier and request a second holder for the unsecured oxygen cylinder.

The licensee's Safe Oxygen Use and Storage policy dated October 16, 2019, indicated oxygen containers must be secured in a stand or a cart so they cannot be knocked over while in use or

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

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02310	Continued From page 59 storage and must not be located in areas where they may be overturned due to a door opening or where they are in a pathway. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days On July 7, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three pattern scope.	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 32 current residents, staff, and visitors. 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	03090		

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03090	Continued From page 60 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). The findings include: On July 5, 2022, at 10:15 a.m., the surveyor entered the facility. The following signage was posted in the entrance/common area: "[facility name] reserves the right to install security cameras in work areas for specific business reasons, such as security, theft protection or protection of proprietary information. 1. [facility name] may find it necessary to monitor work areas with security cameras when there is a specific job - or business - related reason to do so. The company will do so only after first ensuring that such action follows state and federal laws. 2. Those entering should not have any expectation of privacy in work-related areas. 3. Employee privacy in nonwork areas will be respected to the extent possible. Legal advice will be sought in advance in such rare cases where nonwork-area privacy must be compromised. 4. Inquiries regarding this policy will be referred to the MN [Minnesota] Assisted Living statute pertaining to electronic monitoring" On July 5, 2022, at 12:20 p.m., owner (O)-C stated the facility has several cameras throughout the facility in the main corridors and in common areas. The cameras record video for up to 30 days and then they are reset. O-C confirmed the electronic monitoring signage posted did not include the statutory language as required. No further information was provided.	03090		

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03090	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/06/22*
Time: 15:48:48
Report: 7935221149

Food and Beverage Establishment Inspection Report

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

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

License Categories:

Expires on: / /

Operator:

Phone #: 2184432426
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: Pasteurized Eggs and Ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Aurora Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Walk In Cooler
Violation Issued: No

Type: Full
Date: *07/06/22*
Time: 15:48:48
Report: 7935221149
Lilac Home Enh As Liv Mem Care

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221149 of 07/06/22.

Certified Food Protection Manager: William Nelson

Certification Number: 53385 Expires: 05/08/25

Signed: _____ Signed: 7935

Establishment Representative

651-201-4500
health.foodlodging@state.mn.us

Report #: 7935221149

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	07/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	15:48:48
Legal Authority MN Rules Chapter 4626		Time Out	

Lilac Home Enh As Liv Mem Care	Address: 1500 Southwood Drive	City/State: Dilworth, MN	Zip Code: 56529	Telephone: 2184432426
License/Permit #: 0039417	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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	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	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:** 07/06/22

Inspector (Signature) 7935