STATE LICENSING COMPLIANCE REPORT

Report #: HL289899789C **Date Concluded: February 22, 2024**

Name, Address, and County of Facility Investigated:
Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28989	A. BUILDING: _____ B. WING _____	C 02/22/2024

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

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL289899789C On February 22, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 23 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL289899789C, tag identification 0470, 0510, 1300.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 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 observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location, in accordance with Minnesota Administrative Rule 4659.0180, accessible to staff, residents, volunteers, and the public as required. This had the potential to 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	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 22, 2024, at 7:00 a.m., the posted staffing schedule was observed to reflect staffing for February 19, 2024. On February 22, 2024, at 8:50 a.m., licensed practical nurse (LPN)-C was observed updating the white board to show staffing in place for the day. On February 23, 2024, at 2:10 p.m. LPN-C confirmed the posting of staffing hours was not updated daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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	0 510		

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0 510	Continued From page 3 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control (IC) program that complies with accepted health care, medical and nursing standards for infection control for hand hygiene for two of two unlicensed personnel (ULP)-A and ULP-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE On February 22, 2024, the following observations were made: -At 7:15 a.m., ULP-A was observed toileting a resident and then pushed the resident in a wheelchair out of her room while wearing the same soiled gloves. ULP-A failed to perform hand hygiene or remove the soiled gloves before leaving the room. -At 7:50 a.m., ULP-A entered the medication room while wearing gloves. -At 8:10 a.m., ULP-B brought medications and eye drops to a resident sitting at the dining room	0 510		

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0 510	Continued From page 4 table. ULP-B donned gloves, left the table and went to the resident's room to retrieve a pair of glasses. ULP-B placed the glasses on the table and then proceeded to administer eye drops to the resident. ULP-B failed to perform hand hygiene or remove the soiled gloves before administering eye drops. -At 8:15 a.m., ULP-A was observed exiting a resident's room while wearing gloves. ULP-A retrieved clean linens and carried them back to the resident's room while wearing soiled gloves. -At 8:20 a.m., ULP-A was observed wearing a pair of gloves while carrying a clean towel to clean up a juice spill. -At 8:35 a.m., ULP-A was observed passing out glasses of water to residents at the dining room table while wearing gloves. CLEANING OF SUPPLIES On February 22, 2024, at 8:40 a.m., ULP-B took an oral syringe from a cupboard to draw up some liquid Tylenol for R1. The oral syringe had residual, light pink Tylenol still in the tip. ULP-B failed to ensure the oral syringe was cleaned and proceeded to draw up liquid Tylenol and administered it to R1. ULP-B brought the syringe back to the medication room and put the syringe back in the cupboard without cleaning it. Residual, light pink Tylenol was observed in the tip. On February 27, 2024, at 12:20 p.m., licensed practical nurse (LPN)-C confirmed gloves should not be worn while leaving a resident room and should be removed immediately after providing cares. LPN-C confirmed the oral syringe should be cleaned after each use and confirmed it was not being consistently cleaned. No further information provided.	0 510		

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0 510	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01300 SS=F	144G.60 Subd. 2 Qualifications, training, and competency All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs; and promote and be trained to support the assisted living bill of rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a unlicensed personnel was trained and competent in the provision of services with current practice standards appropriate to the residents' needs for one of one employees (ULP-B) reviewed. This had the potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). Findings include: R2 R2's diagnoses included Alzheimer's disease, dementia, and low back pain.	01300		

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01300	Continued From page 6 R2's service plan dated February 9, 2024, indicated the resident received medication management services, including medication administration. R2's progress notes indicated on February 21, 2024, R2's hospice provider had changed the resident's medications and scheduled Morphine to be given twice daily in the morning and evening due to increased pain. R2's February 2024 medication administration record (MAR) indicated 0.26 milligrams (mg)/ milliliter (mL) of Morphine 20 mg/mL was administered on February 22, 2024, at 7:18 a.m. On February 22, 2024, at 7:15 a.m., the investigator observed unlicensed personnel (ULP)-B remove a pre filled syringe out of a plastic bag and click "administer" on the MAR. ULP-B also updated the narcotic count to reflect one syringe of Morphine was used. On February 22, 2024, at 7:20 a.m., ULP-B attempted to administer morphine to R2. R2 refused the medication after several attempts. ULP-B brought the medication back to the medication room and placed the syringe in a cup labeled with the resident's name and put it in the locked cabinet. On February 22, 2024, at 8:20 a.m., ULP-B attempted to administer morphine to R2. R2 again refused after several attempts. ULP-B brought the medication back to the medication room. On February 22, 2024, at 10:30 a.m., ULP-B informed the investigator that another ULP was	01300		

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01300	Continued From page 7 able to get the resident to take her scheduled Morphine. On February 22, 2024, at 12:20 p.m., licensed practical nurse (LPN)-C confirmed staff should not click "administer" until the medication was actually taken by the resident and the 7:18 a.m. documentation would be inaccurate. R3 R3's diagnoses included cognitive dysfunction and chronic pain. R3's service plan dated January 2, 2024, indicated the resident received medication management services, including medication administration. R3's record contained an order dated January 2, 2024, for Atenolol 100 mg tablet once a day. The medication was used to treat high blood pressure and the electronic medical record prompted the medication to be held if the resident's pulse was below 60. R3's February 2024 vital sign record and February 2024 MAR included the following: On February 2, 2024, R3's pulse was 52. The resident's Atenolol was administered as ordered. On February 4, 2024, R3's pulse was 53. The resident's Atenolol was administered as ordered. On February 9, 2024, R3's pulse was 58. The resident's Atenolol was held because "pulse below 60. It is 58." On February 22, 2024, R3's pulse was documented as 60, however the reading was observed to be 58. The resident's Atenolol was administered as ordered.	01300		

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01300	Continued From page 8 On February 22, 2024, at 7:45 a.m., the investigator observed ULP-B taking R3's blood pressure and pulse with an electronic blood pressure cuff. The investigator observed the reading to be 178/91 for blood pressure and 58 for pulse. On February 22, 2024, at 7:50 a.m., ULP-B attempted entering 178/91 in the resident's electronic medical record. The electronic medical record flagged the blood pressure result as high and advised to call the nurse. ULP-B called LPN-C but did not get an answer. ULP-B then called licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D to advise of the high blood pressure and that the resident had a headache. ULP-B did not report to LALD/CNS-D the resident's pulse rate. ULP-B stated LALD/CNS-D advised her to administer his medications as prescribed since the resident had reported pain. After hanging up the phone, ULP-B documented the resident's blood pressure as 170/91 with a note reading "resident bloos pusser is higher that the usual (sic)" ULP-B then recorded the resident's pulse as 60. R2 received his medications as prescribed at 7:55 a.m. On February 23, 2024, at 2:10 p.m., LPN-C stated she interviewed ULP-B about the discrespancy and stated the blood pressure monitor's screen could show as an 8 if it was held at a certain angle and she had ULP-B show her the past few readings and saw one that showed 170/91. LPN-C stated she did not see what the pulse reading was but would go back and look. LPN-C confirmed the order itself did not contain parameters but within the electronic charting system it indicated the medication should not be given if pulse was below 60. LALD-D confirmed since the order did not have parameters, the	01300		

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01300	Continued From page 9 February 9, 2024, holding of the medication would be considered an error. R4 R4's diagnoses included dementia with behavioral disturbances and type two diabetes. R4's service plan dated April 24, 2023, indicated the resident received services including blood glucose management and medication management, including the administration of insulin. R4's MAR indicated the resident received a Humalog Kwikpen (a fast acting insulin that lowers blood sugar) 100 units (u)/milliliter (mL), prime pen with 2 units before each use. Inject 26 units subcutaneously (under the skin) three times daily. Hold if blood sugar is below 110. On February 22, 2024, at 7:25 a.m., ULP-B was observed taking a Humalog pen out of the medication room to administer to R4. The investigator observed instructions on the MAR indicating staff should prime the pen with 2 units before administering the medication. ULP-B failed to prime the insulin pen. ULP-B brought the pen and other medications out to R4, who was sitting at the dining room table. ULP-B was observed to administer Humalog to R4 without priming the pen. On February 22, 2024, at 12:20 p.m., LPN-C confirmed staff should be priming the insulin pen prior to administering it. ULP-B ULP-B was hired on January 31, 2020, to provide direct care and services to the licensee's	01300		

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01300	Continued From page 10 residents, including administer medications. ULP-B's job title was a lead caregiver and was responsible for training other unlicensed personnel. Medication error reports indicated ULP-B made a medication error on December 19, 2023, after signing off that she gave a medication at 8:00 a.m. but it was actually given at 1:30 p.m. A second medication error report indicated ULP-B made another medication error on December 20, 2023, after the nurse noticed 8 a.m. medications were not signed off on by 11:00 a.m. ULP-B reported to the nurse medications had been given at the appropriate time. It was later noted the medication was not given after the resident's family reviewed electronic monitoring that was in place. ULP-B's employee record contained an Employee Event Record dated December 22, 2023. The record indicated ULP-B received a corrective action after she had documented she administered a nebulizer at 8:07 a.m. However, a family member had observed via a camera in the resident's room that the nebulizer was not given until 1:20 p.m. The corrective action indicated "continued behaviors like the one stated above may result in termination." ULP-B's employee record contained a performance improvement plan (PIP) dated January 5, 2024. The PIP was initiated after the employee was "written up for improper medication administration and documentation." ULP-B received education and training regarding medication administration and documentation from LPN-C on the following dates: January 25, 2024, January 18, 2024, January 16, 2024,	01300		

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01300	Continued From page 11 January 2, 2024, and December 22, 2024. ULP-B's record contained documentation of annual training completed on February 10, 2024 which included training on topics related to the facility's policies and procedures and the Assisted Living Bill of Rights. ULP-B completed online education for medication administration on January 10, 2024. On February 23, 2024, at 2:20 p.m., licensed assisted living director (LALD)-D stated they had "done so much extra training with her [ULP-B]...we don't train that way." LALD-D stated they had been working with ULP-B to ensure she was competent to administer medications and would continue re educating the employee. No further information provided. TIME PERIOD TO CORRECTION: Twenty-one (21) Days	01300		