Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 12, 2025

Licensee
Lilly J's Housing and Services LLC
111 63 1/2 Way Northeast
Fridley, MN 55432

RE: Project Number(s) SL39985015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 30, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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.

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order

receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Survey, Supervisor
State Evaluation Team
Email: Kelly Thorson
Telephone: Kelly.Thorson@state.mn.us Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39985	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILLY J'S HOUSING AND SERVICES LLC	111 63 1/2 WAY NE FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#39985015 On April 28, 2025, through April 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 2 residents; 2 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-B, (ULP)-C). 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	0 650		

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0 650	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 28, 2025, at 11:34 a.m., LALD/CNS-A stated the licensee was aware of the required contents of the employee record. The findings include: LALD/CNS-A was hired on April 2, 2024, to provide direct care services to residents and supervision of staff. LALD/CNS-A's employee record lacked the following: -evidence of current professional licensure, registration, or certification if licensure registration, or certification is required by this chapter or rules -records of orientation and infection control training. -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision -documentation of background study as required under section 144.057 -verification that required health screenings under subdivision 9 (nine) have taken place and the dates of those screenings ULP-B was hired on November 14, 2024, to provide direct care services for residernts. On April 29, 2025, at 12:13 p.m., the surveyor observed ULP-B provide noon meal assistance to R2 and R3.	0 650		

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0 650	Continued From page 3 ULP-B's employee record lacked the following: -records of orientation -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision -verification that required health screenings under subdivision 9 (nine) have taken place and the dates of those screenings ULP-C was hired on November 13, 2024, to provide direct care services for residents. ULP-C's employee record lacked the following: -records of orientation -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision -verification that required health screenings under subdivision 9 (nine) have taken place and the dates of those screenings On April 29, 2025, at 12:08 p.m., LALD/CNS-A stated, "I looked for the forms but there not there, I guess I just missed it". LALD/CNS-A stated she was unaware all the forms needed to be in the employee files. The licensee's Personnel Records policy dated January 31, 2022, indicated a record for each paid employee providing assisted living services for [the facility] will be maintained. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: -Evidence of current professional licensure, registration or certification -results of background studies -records of annual training and infection control	0 650		

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0 650	Continued From page 4 training -documentation of orientation -documentation of supervision, as applicable -performance reviews -competency evaluations -signed job description -documentation of annul performance reviews identifying areas of improvement needed and training needs. Results of required health screening and medical examinations will be maintained in a separate, private file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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.	0 660		

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0 660	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for three of three employees, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-B, (ULP)-C), a completed health history and symptom screening for two of three employees, LALD/CNS-A and ULP-B, initial TB training for one of three employees, LALD/CNS-A and a TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on April 28, 2025, at 11:27 a.m., LALD/CNS-A stated the licensee was familiar with current minimum assisted living requirements. The facility did not have a TB risk assessment. LALD/CNS-A was hired on April 2, 2024, to provide direct care services to residents and supervision of staff.	0 660		

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0 660	Continued From page 6 LALD/CNS-A's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed within 90-days of hire and evidence a TB history and symptom screening was completed. ULP-B was hired on November 14, 2024, to provide direct care services to residents. ULP-B's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed within 90-days of hire and evidence a TB history and symptom screening was completed. ULP-C was hired on November 13, 2024, to provide direct care services for residents. ULP-C's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed. On April 29, 2025, at 10:22 a.m., LALD/CNS-A stated she was not aware a TB risk assessment for the facility was required and had not completed one. She confirmed ULP-B's and ULP-C's records were missing a TST or a blood test at time of hire and ULP-B had not completed a TB history and symptom screen. LALD/CNS-A stated, "I guess I missed those things". On April 29, 2025, at 12:23 p.m., LALD/CNS-A stated she had TB testing at another place of employment greater than 90 days prior to her start date, she did not complete a history and symptom screen. She stated, "I don't know why I thought I was excluded from all of these requirements, I haven't done any of it".	0 660		

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0 660	Continued From page 7 The licensee's Tuberculosis Screening/Prevention policy dated January 31, 2022, indicated the facility will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: risk assessment, TB screening, and staff education. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 8 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff and 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, 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). On April 29, 2025, at approximately 10:30 a.m., the surveyor toured the facility with licensed	0 780		

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0 780	Continued From page 9 assisted living director /clinical nurse supervisor (LALD/CNS)-A. During the tour, the surveyor observed unoccupied resident room 4 lacked the required smoke alarm. Smoke alarms are required in each bedroom, outside each separate sleeping area in the immediate vicinity of bedrooms, and on each story within a dwelling unit. On April 29, 2025, LALD/CNS-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 10 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 April 29, 2025, at approximately 10:30 a.m., the surveyor toured the facility with licensed assisted living director /clinical nurse supervisor (LALD/CNS)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. On April 29, 2025, the surveyor explained to LALD/CNS-A that the portable fire extinguishers must be provided monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 800		

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0 800	Continued From page 11 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 physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 29, 2025, at approximately 10:30 a.m., the surveyor toured the facility with licensed assisted living director /clinical nurse supervisor (LALD/CNS)-A. The following was observed. UNOCCUPIED BEDROOM EGRESS WINDOW: The egress window in bedroom 4 had hardware that was not maintained in proper working condition.	0 800		

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0 800	Continued From page 12 On April 29, 2025, LALD/CNS-A stated the room is currently used as an office but plan to use it as a sleeping room in the future and they would address the above deficiency. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 13 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 29, 2025, licensed assisted living director /clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine,	0 810		

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0 810	Continued From page 14 and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as a fire alarm system. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have a fire alarm system. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On April 29, 2025, LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the	01460		

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01460	Continued From page 15 staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided prior to providing assisted living services to residents for one of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A). 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	01460		

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01460	Continued From page 16 the residents). The findings include: LALD/CNS-A was hired on April 2, 2024 to provide direct care services to residents and supervision of staff. LALD/CNS-A record lacked evidence orientation was completed for the following required topics: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -handling emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -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 -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 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.	01460		

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01460	Continued From page 17 On April 29, 2025, at 12:23 p.m., LALD/CNS-A stated she had completed 8 (eight) hours of dementia training. She had not completed any of the additional required orientation. LALD/CNS-A stated, " I don't know why I thought I was excluded from all of these requirements, and I haven't done any of it." The licensee's Staff Orientation and Education policy dated January 31, 2022, indicated all staff providing assisted living through [the facility] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. No one may provide direct care to residents on behalf of [the facility] before successfully completing the organizations orientation program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=F	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	01470		

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01470	Continued From page 18 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise 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 staff member 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,	01470		

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01470	Continued From page 19 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired on November 13, 2024, to provide direct care services for residents. ULP-C's employee record lacked the following required orientation content: -overview of assisted living statutes -review of provider's policies and procedures -handing of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of types of assisted living services the employee will provide and provider's scope of license	01470		

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01470	Continued From page 20 -principles of person-centered planning/service delivery On April 29, 2025, at 11:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "I thought I had all of them assigned as needed, I did not know any were missing. Educare (training program) assigns so many, I guess I removed some that were required". The licensee's Staff Orientation and Education policy dated January 31, 2022, indicated all staff providing assisted living through [the facility] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. No one may provide direct care to residents on behalf of [the facility] before successfully completing the organizations orientation program. Orientation topics will include: -overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person -grievance policy/process, including reports to the Office of Health Facility Complaints -consumer advocacy services -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure -the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff	01470		

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01470	Continued From page 21 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a 14-day resident reassessment for one of two residents (R2).	01620		

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01620	Continued From page 22 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: During the entrance conference on April 28, 2025, at 11:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated resident's comprehensive assessments are completed upon admission date, 14-days after, every 90 days thereafter or upon change of condition. R2 was admitted to the licensee on November 19, 2024. R2's diagnoses included cerebrovascular accident, pulmonary fibrosis and prediabetes. R2's service plan dated November 20, 2024, indicated R2 received services to include medication administration, dressing, toileting, bathing, meals, laundry, housekeeping and vital sign monitoring. On April 29, 2025, at 12:13 p.m., the surveyor observed ULP-B provide noon meal assistance to R2. R2's record included an admission assessment dated November 19, 2024, and two (2) 90-day assessments dated January 16, 2025, and March 30, 2025. R2's record lacked a 14-day	01620		

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01620	Continued From page 23 assessment. On April 28, 2025, at 1:40 p.m., LALD/CNS-A stated she did not complete a 14-day assessment, she was not aware it was required at the time of R2's admission. The licensee's Assessment and Reassessment policy dated January 31, 2022, indicated the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:	01790		

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01790	Continued From page 24 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

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01790	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-B, ULP-C) 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: ULP-B was hired on November 14, 2024, to provide direct care services for residents. ULP-B's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-C was hired on November 13, 2024, to provide direct care services for residents. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On April 29, 2025, at 11:46 a.m. licensed assisted living director/clinical nurse supervisor	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39985	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILLY J'S HOUSING AND SERVICES LLC	111 63 1/2 WAY NE FRIDLEY, MN 55432

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01790	Continued From page 26 (LALD/CNS)-A stated she prepares all medications for residents that have unplanned time away and had not completed any training or competencies for the unlicensed staff. The licensee's Medication Management Plan for Residents Away from Home policy dated January 31, 2022, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse (RN) in a timely manner, the registered nurse may delegate to an unlicensed personnel to provide the medications based on the following: - the RN has trained the home health aide and determined the home health aide competency to follow procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39985	A. BUILDING: _____ B. WING _____	04/30/2025

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LILLY J'S HOUSING AND SERVICES LLC	111 63 1/2 WAY NE FRIDLEY, MN 55432

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01910	Continued From page 27 and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 discharged from licensee on February 22, 2025. R2's discharge summary indicated R2 received medication management services. R2's record lacked evidence of documentation of R2's disposition of medications to include prescription number if applicable, quantity, to	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39985	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 28 whom the medications were given, and the names of the staff and other individuals involved in the disposition. On April 28, 2025, at 12:21 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she signed the narcotic log count sheet indicating she had given the narcotic medications to family, but did not list any of the other medications. LALD/CNS-A stated she was not aware this needed to be done. The licensee's Disposition and Disposal of Medications policy dated January 31, 2022, indicated upon disposition, [the facility] will document the following information in the clinical record: -name, strength, and prescription number of medication, as applicable -quantity -method of disposition or to whom the medications were given -date of disposition -name/signature of staff or other individuals involved in disposition -if applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Lilly JS Housing and Services
111 63 1/2 Way Northeast
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 39985

Risk:
License:
Expires on:
CFPM: Natalie Suckoo
CFPM #: 34278; Exp: 3/2/2028

Inspection Info

Report Number: F7963251003
Inspection Type: Full - Single
Date: 4/29/2025 Time: 11:58:16 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS INSPECTION WAS COMPLETED WITH ESTABLISHMENT REPRESENTATIVES NATALIE SUCKOO AND CLOVER GILLUM. DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-VOMIT/FECAL CLEANUP
-HIGHLY SUSCEPTIBLE POPULATION FACT SHEET
-DEFINITION OF SAME-DAY SERVICE

KITCHEN HAS SMOOTH, PAINTED WALLS AND CEILINGS, SHEET LINOLEUM FLOORING, LAMINATE COUNTERTOPS AND WOOD CABINETS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7963251003 from 4/29/2025

Natalie Suckoo
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Lilly JS Housing and Services
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F7963251003
Inspection Type: Full
Date: 4/29/2025
Time: 11:58:16 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HAM**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Lilly JS Housing and Services
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F7963251003
Inspection Type: Full
Date: 4/29/2025
Time: 11:58:16 AM

Sanitizing Equipment: **Product:** DISHWASHER RINSE**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No