Electronically Delivered

July 21, 2025

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

RE: Project Number(s) SL29018016

Dear Licensee:

On June 3, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 12, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Electronically Delivered

April 10, 2025

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

RE: Project Number(s) SL29018016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	03/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL29018016-0 On March 10, 2025, through March 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 119 residents; 69 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on March 11, 2025, at a level 3/Widespread (I) The licensee took action on March 11, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
01290 SS=I	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 a staff member 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 current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living with dementia care license for one of 59 employees (unlicensed personnel (ULP)-F). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on March 11, 2025. 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,	01290		

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01290	Continued From page 4 or a violation that has the potential to lead to 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: ULP-F was hired on February 28, 2023, to provide direct care services for the licensee's residents. On March 10, 2025, at 1:30 p.m., the surveyor observed ULP-F administer afternoon medications to R1. ULP-F was providing direct care services the licensee's residents without supervision. On March 10, 2025, at 3:30 p.m., the surveyor received the licensee's employee roster, and the licensee's NETStudy 2.0 roster; both documents were printed on March 10, 2025. On March 10, 2025, at 3:50 p.m., the surveyor met with licensed assisted living director (LALD)-A to clarify some employees were not found on the licensee's NETStudy 2.0 roster. LALD-A stated some employees had name changes (due to marriage) and she would review the lists to clarify. On March 11, 2025, at 9:25 a.m., regional vice president of operations (RVPO)-I stated after review of the employee roster and the NETStudy roster provided the previous day, he and LALD-A determined that ULP-F had not fully completed her background study process at the time of hire in 2023. As a result, her background study was not finished. RVPO-I stated ULP-F had been	01290		

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01290	Continued From page 5 pulled from the schedule and sent to get her fingerprints completed and would not return for duty until her background study was fully cleared. On March 11, 2025, at 10:10 a.m., a further review of ULP-F's NETStudy 2.0 roster information indicated ULP-F had previously initiated the process for a background study on February 28, 2023; however, ULP-F failed to complete the consent during the background study process at that time; resulting in the background study being "closed" on March 15, 2023. The NETStudy 2.0 roster further indicated LALD-A had reinitiated ULP-F's background clearance process on March 10, 2025, at 4:48 p.m. On March 11, 2025, at 10:50 a.m., LALD-A stated when it was determined ULP-F's background clearance had not been completed from 2023, she reinitiated the background study process on March 10, 2025. LALD-A stated ULP-F had been providing direct care without direct supervision since 2023. The licensee's Background Studies policy dated August 1, 2021, [licensee name] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee name]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [licensee name] will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01290	Continued From page 6 The licensee took action on March 11, 2025; however, the scope and level remain at I.	01290		
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 conduct a comprehensive reassessment with a change of condition for one of four residents (R6).	01620		

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01620	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on March 10, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-B and vice president of clinical services/registered nurse (VPCS/RN)-C reviewed the comprehensive assessment schedule and indicated the RN completed a comprehensive assessment with a change in condition which included when a resident started hospice services. R6's diagnoses included dementia and epilepsy (seizure disorder). R6's Service Plan dated December 3, 2024, indicated R6 received services to include medication administration, assistance with dressing, bathing, toileting, transfers with assist of two and Hoyer lift, and behavior management. On March 11, 2025, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-M administer one oral medication and transferred R6 to bed with assistance from ULP-E using a Hoyer lift (mechanical lift). ULP-M changed R6's incontinence brief and positioned her in bed to rest. On March 11, 2025, at 1:15 p.m., the surveyor requested the three most recent comprehensive	01620		

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01620	Continued From page 8 assessments completed for R6. R6's record included the following comprehensive assessments: - November 20, 2024, indicated a 14-day assessment; - January 29, 2025, indicated an annual review assessment; and - February 12, 2025, indicated 90-day assessment R6's progress notes included: - December 13, 2024, patient discharged from physical therapy on December 11, 2024. Patient was seen for five sessions and has reached maximum potential. Bed mobility and transfers are now max assist too dependent with performance, level varying throughout the day. Client (resident) is sleeping more hours throughout the day. There has been an increased need for the use a mechanical lift to complete transfers. Hospice evaluation will be pursued. - December 26, 2024, and indicated R6 started hospice services, with an admitting diagnosis of anemia. The licensee failed to ensure a comprehensive assessment was completed with a change of condition with R6's evaluation and enrollment with hospice services. On March 12, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated, "I did not complete an assessment as I rationalized [R6] really did not have a "change in condition", but just started hospice, and I talked myself out of completing one." The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated	01620		

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01620	Continued From page 9 "Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure nurse delegated procedures were followed by one of one unlicensed personnel (ULP-F) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	02320		

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02320	Continued From page 10 R1 R1 was admitted on November 15, 2024, with diagnoses that included type 2 diabetes and chronic kidney disease. R1's service plan dated November 15, 2024, indicated R1 received the service of medication administration. R1's signed prescriber orders dated February 18, 2025, included: -acetaminophen 500 milligrams (mg), two tablets by mouth three times daily (for pain); -Centrum multivitamin, one tablet by mouth daily (supplement); -ferrous sulfate, 325 mg, one tablet by mouth daily (iron deficiency); -melatonin 10 mg, one tablet by mouth, daily at bedtime (sleep); and -Vitamin D3, 125 microgram (mcg), one tablet by mouth daily (supplement) R1's service schedule instructions as noted for March 10, 2025, at 1:30 p.m., indicated "Please administer medications from the appropriately labeled bubble pack making sure the bubble pack and medication administration record (MAR) match. After removing the pill from the bubble pack, initial and date each card the pill was removed from. Initial each medication given on the MAR." On March 10, 2025, at 1:30 p.m., the surveyor observed ULP-F enter R1's apartment, unlock R1's medication cupboard and remove R1's medication bucket. ULP-F washed her hands, removed R1's acetaminophen bubble pack from the bucket, punched out the two tablets in the next available bubble, placing in a medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	03/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 11 cup, and administer the tablets with a glass of water. ULP-F then went back to the medication cupboard and pulled out R1's medication 3 ring binder, opened the binder to the MAR, placed her initials in the designated spot for acetaminophen for 2:00 p.m. time for March 10, 2025. ULP-F then wrote the date and her initials on the bubble pack next to the bubble she removed the medications from. R2 R2 was admitted on April 26, 2021, with diagnoses that included dementia with behavioral disturbance. R2's service plan dated October 1, 2024, indicated R2 received the service of medication administration. R2's signed prescriber orders dated February 4, 2025, included: -albuterol 2.5 mg/3 milliliters (ml), inhaled twice daily (cough/wheezing); -citalopram hydrobromide 20 mg, one tablet daily (anxiety); -furosemide 20 mg, one tablet daily (fluid retention); -haloperidol 0.5 mg, one tablet three times daily (agitation); -acetaminophen 650 mg suppository, give one suppository rectally every four hours as needed for a fever; -albuterol 2.5 mg/3 ml inhaled every four hours as needed for shortness of breath; -bisacodyl 10 mg suppository, give one suppository daily as needed when no bowel movement in 72 hours; -haloperidol 0.5 mg, give one tablet every four hours as needed (agitation);	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	03/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 12 -hydromorphone 1 mg, give one solutab (dissolved under the tongue), every one hour as needed for shortness of breath or pain; -hyoscyamine sulfate 0.12 mg, give one tablet under the tongue every 4 hours as needed for excessive secretions; -Icy Hot lidocaine 1% cream, apply to neck twice daily as needed for pain; -lorazepam 0.5 mg, give one tablet by mouth every 4 hours as needed for anxiety and restlessness; and -miconazole powder, apply to redness on skin twice daily as needed until healed On March 10, 2025, at 1:37 p.m., the surveyor observed ULP-F enter R2's apartment, unlock R2's medication cupboard and removed R2's medication bucket. ULP-F washed her hands, removed R2's haloperidol bubble pack from the bucket, punched out one tablet in the next available bubble, placed the tablet in a medication cup, and administered the tablet with a glass of water. ULP-F then went back to the medication cupboard and pulled out R2's medication 3 ring binder, opened the binder to the MAR, placed her initials in the designated spot for haloperidol for 2:00 p.m. time for March 10, 2025. ULP-F then wrote the date and her initials on the bubble pack next to the bubble she removed the medications from. ULP-F's employee file included her "Oral medications Competency" check off as completed and signed by the registered nurse (RN) on March 15, 2023. The document indicated ULP-F was trained and competent in following the proper steps in oral medication administration. ULP-F failed to follow the proper steps in medication administration to ensure all "rights" of	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	03/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 13 medication administration were followed for both R1 and R2. ULP-F failed to first check the bubble pack label and compare it to the information in the medication book on the MAR which included ensuring the resident had the right medication, right dose, right time, right route, and right date. On March 11, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated, "We've talked about this numerous times, and I expect all staff to look at the label and MAR three times prior to administering any medication. We have had a medication error (medication given twice) in the past, likely as the result of staff not checking the MAR first. I will complete retraining with this staff." The licensee's Medication and Treatment-delegation and administration policy dated August 1, 2021, indicated: 5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: _____ B. WING _____	03/12/2025

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

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02320	Continued From page 14 administration or treatment/therapy to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *03/11/25*
Time: 09:00:00
Report: 1031251075

Food and Beverage Establishment Inspection Report

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

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

License Categories:

Expires on: / /

Operator:

Phone #: 6517679545
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.
CONVECTION OVEN INTERIOR HAS ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY.

CLEAN CONVECTION OVEN INTERIOR AND GLASS.
Comply By: 04/02/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sani Bucket 1
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sani Bucket 2
Violation Issued: No

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

Ambient Air Temp: = at 41 Degrees Fahrenheit
Location: Glass Door Cooler (service area)
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/11/25*
Time: 09:00:00
Report: 1031251075
Lilydale Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/Dressing
Temperature: 40 Degrees Fahrenheit - Location: 1-Door Cooler
Violation Issued: No

Process/Item: Cold Hold/Deli Turkey
Temperature: 39 Degrees Fahrenheit - Location: Undercounter Cooler
Violation Issued: No

Process/Item: Hot Hold/Gravy
Temperature: 172 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cold Hold/Chili
Temperature: 38 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

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

Process/Item: Cooking/Chowder
Temperature: 178 Degrees Fahrenheit - Location: Hotel Pan
Violation Issued: No

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

Nurse Evaluator on site: Deb Jacobson

All violations discussed with PIC prior to leaving site.

Location has full commercial kitchen.

Discussed:
- Cooling procedure
- Reheating procedure
- Thermometer use and calibration
- Illness and illness log

Est. uses pasteurized eggs and does not undercook foods.

ILLNESS COMPLAINT PROCEDURE:
If a customer/resident complains of a possible food illness take these steps:
1. Gather as much information from the customer as possible, such as: name, phone#, date of illness, food consumed.
2. Give customer the illness hotline phone number: 1-877-366-3455.
3. Contact your health inspector: Give inspector information gathered from customer and any other useful information.

Contact inspector prior to any major equipment or building changes; some changes may require plan review to be completed.

Type: Full
Date: *03/11/25*
Time: 09:00:00
Report: 1031251075
Lilydale Senior Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031251075 of 03/11/25.

Certified Food Protection Manager: Jonathan P. Tormoen

Certification Number: 15968 Expires: 09/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jonathan Tormoen
Person in Charge

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