Electronically Delivered

October 3, 2025

Licensee
Hawley Senior Living
923 5th Street
Hawley, MN 56549

RE: Project Number(s) SL30455016

Dear Licensee:

On September 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 25, 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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	R 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWLEY SENIOR LIVING	923 5TH STREET HAWLEY, MN 56549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY INITIAL COMMENTS SL30455016-1 On September 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 25, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota	{0 480}		

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{0 480}	Continued From page 1 Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	

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{0 510}	Continued From page 2	{0 510}		
{0 510} SS=D	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 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:	{0 510}	Not reviewed during this survey.	
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.	
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	{02320}		

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{02320}	Continued From page 3 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}	Not reviewed during this survey.	

Electronically Delivered

August 13, 2025

Licensee
Hawley Senior Living
923 5th Street
Hawley, MN 56549

RE: Project Number(s) SL30455016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 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 3: a fine of $3,000 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 - 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,

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

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0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30455016-0 On June 23, 2025, through June 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 26 residents; 26 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on June 24, 2025, issued for tag identification 1290 at a scope and level of widespread, level three (l). The licensee took mitigating actions, however, the correction order remains at a scope and level of 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, June 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	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 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 ensure infection control standards were followed for one of two employees, (unlicensed personnel (ULP)-K) 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally or in a limited number of locations). The findings include:	0 510		

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0 510	Continued From page 4 On June 24, 2025, at 7:50 a.m., the surveyor observed ULP-K in the process of verifying R1's oral medications and was placing the medications in a cup for administration. ULP-K stated her training consisted of watching videos and completed training with a registered nurse (RN) for medications and insulins. ULP-K removed two insulin pens from the cart. ULP-K retrieved a new insulin pen from the nurse office medication refrigerator. On June 24, 2025, at 8:00 a.m., ULP-K returned with the new insulin pen. Surveyor did not observe ULP-K sanitize hands. ULP-K removed the three insulin pen covers and dialed to two units and primed, then secured the needles on the three insulin pens and dialed the correct doses (surveyor did not observe ULP-K alcohol the tip of the insulin pens or secure the needles before priming). ULP-K dialed the correct units on the insulin pens. On June 24, 2025, at 8:05 a.m., ULP-K and surveyor entered R1's room. ULP-K administered all three insulins to R1's upper left arm, without sanitizing, applying gloves or prepping the injection site with an alcohol pad. R1 had taken his oral medications and ULP-K noticed his catheter bag was laying under his chair. ULP-K picked up the catheter bag and hung it up. ULP-K and surveyor proceeded to the medication cart in the hallway. Without using hand hygiene ULP-K documented medications on the laptop, unlocked the medication cart, and grabbed a medication cup to prepare the next resident's medications. Surveyor stopped ULP-K and questioned if there was something ULP-K should have done, ULP-K then used hand sanitizer on her hands.	0 510		

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0 510	Continued From page 5 On June 24, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-B stated expectations for insulin pen administration was to alcohol the end of the pen, attach needle, prime with two units, dial the prescribed dose, and have another staff member verify the dose. CNS-B further stated, for administration, gloves should be worn and the injection site should be cleaned with an alcohol pad prior to administering the insulin. The licensee's Insulin pen policy dated August 1, 2021, indicated in preparing the insulin pen: 1) Wash hands 2) Gather supplies: electronic medication administration record (EMAR), insulin pen, needle, alcohol wipe Preparing your Pen: 3) Check label on pen to be sure it contains the type of insulin that was prescribed by physician 4) Pull pen cap straight off 5) Check the liquid in the pen, should be clear and colorless unless insulin if suspension (cloudy) 6) If your insulin is suspension (cloudy): a. Roll the pen back and forth between your hands 10 times b. Gently turn the pen up and down 10 times until insulin is evenly mixed 7) Wipe top of pen with alcohol swab 8) Always use a new needle for each injection 9) Push the capped needle straight onto the pen and twist the needle on until tight 10) Pull off outer cap Priming your Pen: 11) Hold the pen with the needle pointing up 12) Turn the dose selector to select 2 units 13) Hold the pen with the needle pointing up. Press and hold dose button until dose counter shows "0". The) (sic) must line up with the dose pointer. A	0 510		

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0 510	Continued From page 6 drop of liquid should be seen at the needle tip. If you do not see a drop repeat above step 12 & 13. If you do not see a drop after 3 tries, change the needle and try again. Selecting your dose: 14) Home Health Aide (HHA) will check EMAR for insulin dose required. HHA will do six (6) rights and 3 label checks with label and electronic EMAR. 15) Turn dose selector to select the number of units you need injected. The dose pointer should line up with your dose. If you select the wrong dose, you can turn the dose forward or backward to the correct dose. The even numbers are printed on the dial; the odd numbers are shown as lines. 16) Co-check: a) HHA to review residents care plan to ensure proper procedure is followed for co-checking. If six (6) rights are correct, second co-check will visually verify. Staff to document on EMAR, location, amount and staff initials that verified. b) When a 2nd staff is in-house, second staff will review the six (6) rights prior to initialing as co-check. If the six (6) rights are correct, second staff will initial in the co-check space in the EMAR. c) When only one (1) staff is in-house, and residents' care plan indicates HHA to notify on-call nurse via company provided cellular device via text message with a picture of insulin being provided. Staff to document on EMAR, location, amount and nurse initials that was notified. d) When only one (1) staff is in-house, and residents' care plan states 'resident is competent to verify correct dosage'; staff will document in EMAR, location, amount and resident initials only to be used when cellular device is not available	0 510		

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0 510	Continued From page 7 The licensee's Medication Administration Procedure policy dated August 1, 2021, indicated the first step is to wash hands and second step is to follow the six rights of medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received for four of four unlicensed personnel (ULP-C, ULP-D, ULP-E, ULP-F)). This had the potential to	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWLEY SENIOR LIVING	923 5TH STREET HAWLEY, MN 56549

(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
01290	Continued From page 8 affect all 26 residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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: During the entrance conference on June 23, 2025, at 10:15 a.m., assisted living director in residency (ALDIR)-A stated ALDIR-A was aware of the required content of the employee record. The licensee's Employee Roster dated June 23, 2025, indicated ULP-C, ULP-D, ULP-E, and ULP-F were current employees of the licensee. ULP-C was hired on November 5, 2024, to provide direct care to the residents of the licensee. ULP-D was hired on January 29, 2025, to provide direct care to the residents of the licensee. ULP-E was hired on March 4, 2025, to provide direct care to the residents of the licensee. ULP-F was hired on March 24, 2025, to provide direct care to the residents of the licensee. The Department of Human Services (DHS) NETStudy 2.0 employee roster dated June 23, 2025, did not include ULP-C, ULP-D, ULP-E, and ULP-F as current employees of the licensee with	01290		

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01290	Continued From page 9 a cleared background study. On June 23, 2025, at 3:56 p.m., ALDIR-A stated ULP-C worked approximately 32 hours per week, ULP-D and ULP-E worked as needed, and ULP-F worked approximately 32-40 hours a week since their hire date. ALDIR-A stated the above employees have worked independently at the facility, and at this time are removed from the schedule. On June 24, 2025, at 8:37 a.m., operations supervisor (OP)-G, stated the licensee received an electronic letter on November 26, 2024, from Department of Human Services (DHS) stating ULP-C may be disqualified from direct care and needs to be continually supervised until results can be determined. On June 24, 2025, at 8:58 a.m., ALDIR-A stated the licensee received an electronic letter from DHS on February 12, 2025, indicating ULP-D's fingerprints and photo were not submitted as required. On June 24, 2025, at 9:00 a.m., ALDIR-A stated the licensee received an electronic letter from DHS on April 21, 2025, indicating ULP-E's documents were not submitted as required. On June 24, 2025, at 9:03 a.m., OP-G stated the DHS BGS registry indicated ULP-F had fingerprints taken on March 27, 2025, however lacked the consent and disclosure form so ULP-F was dropped from the registry. On June 24, 2025, at 9:10 a.m., ALDIR-A stated it was an oversight and will need to look at the current process of obtain background studies.	01290		

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01290	Continued From page 10 The licensee's Background Checks policy dated August 1, 2021, indicated the community will conduct a Minnesota Department of Human Services BGS on all staff of community who will have independent, unsupervised contact with tenants or residents of community. No employee may have independent direct contact with any tenants or residents until acceptable result of the background study have been received. The community will not employ individuals whose results of the BGS indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations for three of three medication carts (North, Middle, South cart). 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	01890		

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01890	Continued From page 11 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: During the entrance conference on June 23, 2025, at 9:30 a.m., assisted living director in residency (ALDIR)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On June 23, 2025, from 11:10 a.m. through 12:00 p.m., the surveyor, CNS-B and assistant director (AD)-J observed the following medications in the north, middle and south medication carts: North cart -R1's opened Lantus 100 units/milliliter (ml) and Novolog 100 units/ml insulin (treats high blood sugar) pens lacked prescription labels; and -R5's opened Lantus 100 units/ml pen lacked prescription label and open and expiration date. Middle cart -R8's opened olopatadine 0.2% (treats eye allergies) eye drops lacked open and expiration dates; and -R9's opened Trelegy Ellipta (treats airflow obstruction) inhaler lacked open and expiration dates. South cart -R2's opened Novolog insulin pen lacked open and expiration dates; -R11's opened Refresh (treats dry eyes) eye drops lacked open and expiration dates; and -R12's opened Stiolto Respimat (treats airflow	01890		

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01890	Continued From page 12 obstruction) inhaler lacked open and expiration dates. On June 23, 2025, at 11:20 a.m., CNS-B stated expectations are all medications should have a pharmacy label and time sensitive medications should be labeled with open and expiration dates. On June 23, 2025, at 11:50 p.m., AD-J stated AD-J completes medication cart audits, and was taught by a previous nurse to just check the manufacturer expiration dates. AD-J further stated she was unaware some of the medications were time sensitive medications and needed to be labeled. The manufacturer instructions for Lantus dated June 2022, indicated to discard the pen after 28 days after it has been opened, even if it still has insulin left in it. The manufacturer instructions for Novolog dated October 2021, indicated to discard the pen after 28 days after it has been opened, even if it still has insulin left in it. The manufacturer instructions for olopatadine dated September 2023, indicated to discard at the end of treatment or 28 days after opening, whichever comes first. The manufacturer instructions for Refresh dated September 2020, indicated to discard 90 days after opening. The manufacturer instructions for Trelegy Ellipta dated June 2023, indicated to discard 6 weeks after you open the tray or when the counter reads "0", whichever comes first.	01890		

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01890	Continued From page 13 The manufacturer instructions for Stiolto Respimat inhaler dated January 2025, indicated to discard 90 days after opening. The licensee's Medication Administration - Procedure policy dated August 1, 2021, indicated the labels will be neat and legible. The nurse may never relabel, it must be sent to pharmacy if re-labeling is necessary. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications shall be stored consistent with manufacturer recommendations when secured storage of the medications is necessary. The registered nurse (RN) will identify where the medications will be stored, and once opened, medications need to be labeled and dated with the open date, expiration date, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	02320		

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02320	Continued From page 14 review, the licensee failed to ensure the steps of the medication administration process for insulin administration was followed for one of two employees (unlicensed personnel (ULP)-K). 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally or in a limited number of locations). The findings include: On June 24, 2025, at 7:50 a.m., the surveyor observed ULP-K was in the process of verifying R1's oral medications and was placing the medications in a cup for administration. ULP-K stated her training consisted of watching videos and completed training with a registered nurse (RN) for medications and insulins. ULP-K removed two insulin pens from the cart. ULP-K retrieved a new insulin pen from the nurse's office medication refrigerator. On June 24, 2025, at 8:00 a.m. ULP-K returned with the new insulin pen. Surveyor did not observe ULP-K sanitize hands. ULP-K removed the three-insulin pen covers and dialed to two units and primed, then secured the needles on the three insulin pens and dialed the correct doses (surveyor did not observe ULP-K alcohol the tip of the insulin pens or secure the needles before priming). ULP-K dialed the correct units on the insulin pens.	02320		

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02320	Continued From page 15 On June 24, 2025, at 8:05 a.m., ULP-K and surveyor entered R1's room. ULP-K administered all three insulins to R1's upper left arm, without sanitizing, applying gloves or prepping the injection site with an alcohol pad. R1 had taken his oral medications and ULP-K noticed his catheter bag was laying under his chair. ULP-K picked up the catheter bag and hung it up. ULP-K and surveyor proceeded to the medication cart in the hallway. Without using hand hygiene ULP-K documented medications on the laptop, unlocked the medication cart, and grabbed a medication cup to prepare the next resident's medications. Surveyor stopped ULP-K and questioned if there was something ULP-K should have done, ULP-K then used hand sanitizer on her hands. On June 24, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-B stated expectations for insulin pen administration was to alcohol the end of the pen, attach needle, prime with two units, dial the prescribed dose, and have another staff member verify the dose. CNS-B further stated, for administration gloves should be worn and the injection site should be cleaned with an alcohol pad prior to administering the insulin. The licensee's Insulin pen policy dated August 1, 2021, indicated in preparing the insulin pen: 1) Wash hands 2) Gather supplies: electronic medication administration record (EMAR), insulin pen, needle, alcohol wipe Preparing your Pen: 3) Check label on pen to be sure it contains the type of insulin that was prescribed by physician 4) Pull pen cap straight off 5) Check the liquid in the pen, should be clear and colorless unless insulin if suspension (cloudy)	02320		

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02320	Continued From page 16 6) If your insulin is suspension (cloudy): a. Roll the pen back and forth between your hands 10 times b. Gently turn the pen up and down 10 times until insulin is evenly mixed 7) Wipe top of pen with alcohol swab 8) Always use a new needle for each injection 9) Push the capped needle straight onto the pen and twist the needle on until tight 10) Pull off outer cap Priming your Pen: 11) Hold the pen with the needle pointing up 12) Turn the dose selector to select 2 units 13) Hold the pen with the needle pointing up. Press and hold dose button until dose counter shows "0". The) (sic) must line up with the dose pointer. A drop of liquid should be seen at the needle tip. If you do not see a drop repeat above step 12 & 13. If you do not see a drop after 3 tries, change the needle and try again. Selecting your dose: 14) (Home Health Aide) HHA will check EMAR for insulin dose required. HHA will do six (6) rights and 3 label checks with label and EMAR. 15) Turn dose selector to select the number of units you need injected. The dose pointer should line up with your dose. If you select the wrong dose, you can turn the dose forward or backward to the correct dose. The even numbers are printed on the dial; the odd numbers are shown as lines. 16) Co-check: a) HHA to review residents care plan to ensure proper procedure is followed for co-checking. If six (6) rights are correct, second co-check will visually verify. Staff to document on EMAR, Location, amount and staff initials that verified. b) When a 2nd staff is in-house, second staff will	02320		

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02320	Continued From page 17 review the six (6) rights prior to initialing as co-check. If the six (6) rights are correct, second staff will initial in the co-check space in the EMAR. c) When only one (1) staff is in-house, and residents' care plan indicates HHA to notify on-call nurse via company provided cellular device via text message with a picture of insulin being provided. Staff to document on EMAR, Location, amount and nurse initials that was notified. d) When only one (1) staff is in-house, and residents' care plan states 'resident is competent to verify correct dosage; staff will document in EMAR, Location, amount and resident initials only to be used when cellular device is not available No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Hawley Senior Living
923 5th Street
Hawley, MN 56549
Clay County
Parcel:

Phone:

License Info

License: HFID 30455

Risk:
License:
Expires on:
CFPM: Tanda Thorson
CFPM #: FM 2688; Exp: 05/26/2026

Inspection Info

Report Number: F1049251071
Inspection Type: Full - Single
Date: 6/24/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: THERE WAS A HALF GALLON OF CHOCOLATE MILK IN THE UPRIGHT COOLER THAT HAD A MANUFACTURER'S USE-BY DATE OF 06/23/2025. PIC DISCARDED THE HALF GALLON OF CHOCOLATE MILK DURING THE INSPECTION. VIOLATION WAS CORRECTED ON SITE.
Comply By: Complied On Site Originally Issued On: 6/24/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT: IN THE KITCHEN, THE MICROWAVE HAD ACCUMULATION OF FOOD DEBRIS. PIC INSTRUCTED TO CLEAN THE MICROWAVE ACCORDINGLY.
Comply By: 6/24/2025 Originally Issued On: 6/24/2025

Food & Beverage General Comment

INSPECTOR MET WITH MDH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

THE ESTABLISHMENT OPERATES A COMMERCIAL KITCHEN WITH STAINLESS STEEL COUNTER TOPS, TILE FLOORING, FRP WALLS, AND PAINTED CEILING.

Things to Remember:

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

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

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

be done and how to properly wash hands.

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

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 Fergus Falls District Office inspection report number F1049251071 from 6/24/2025

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Hawley Senior Living
Hawley
County/Group: Clay County

Inspection Info

Report Number: F1049251071
Inspection Type: Full
Date: 6/24/2025
Time: 11:30 AM

Food Temperature: Product/Item/Unit: Potato Salad**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cottage Cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Diced Potatoes**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 33 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Hawley Senior Living
Hawley
County/Group: Clay County

Inspection Info

Report Number: F1049251071
Inspection Type: Full
Date: 6/24/2025
Time: 11:30 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 172.2 Degrees F.
Comment:
Violation Issued?: No