Electronically Delivered

April 25, 2023

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

RE: Project Number(s) SL30455015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the MDH imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH imposes a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

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 _____	04/19/2023

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 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#30455015 On April 17, 2023, through April 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 33 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 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 three employees (unlicensed personnel (ULP)-F) 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: On April 18, 2023, at 7:18 a.m., the surveyor observed ULP-F log into the electronic record and start the insulin administration process for R5. ULP-F did not complete hand hygiene prior to preparing R5's scheduled insulin. At 7:19 a.m., the surveyor observed ULP-F administer R5's scheduled insulin without donning gloves, return to the electronic record and documented R5's	0 510		

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0 510	Continued From page 2	0 510		

insulin as administered. The surveyor did not observe ULP-F perform hand hygiene or don and doff gloves.

On April 18, 2023, at 7:23 a.m., the surveyor observed ULP-F start the medication process including insulin for R2. ULP-F did not complete hand hygiene prior to preparing R2's scheduled oral medication and insulin. At 7:24 a.m., the surveyor observed ULP-F administer R2's scheduled oral medication and then proceeded to administer R2's insulin without donning gloves. ULP-F returned to the electronic record and documented R2's oral medication and insulin was administered. The surveyor did not observe ULP-F perform hand hygiene or don and doff gloves. ULP-F proceeded to start the same medication process for another resident.

On April 18, 2023, at 7:32 a.m., ULP-F stated he usually washed his hands or used hand sanitizer before and after medication administration. ULP-F stated he did not wash his hands or use hand sanitizer before or after R5 and R8's medication administration and should have. ULP-F stated he did not don gloves as they (gloves) are hard to get on and off and it was not quick to don and doff the gloves.

On April 18, 2023, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated the expectation of staff to complete hand hygiene should be between each resident contact and gloves should be worn anytime there was exposure to bodily fluids.

The licensee's Hand Washing policy dated August 1, 2021, indicated hand washing will be performed by all employees between resident tasks and procedure.

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0 510	Continued From page 3 The licensee's Standard Precautions dated August 1, 2021, indicated gloves would be donned when touching blood or bodily fluids and then doffed followed by hand washing. The licensee's Insulin Pen policy dated August 1, 2021, indicated before ULPs administer insulin to wash hands and don gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program	0 660		

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0 660	Continued From page 4 based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-F). 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: The facility's TB risk assessment was completed on August 1, 2021, and the facility was determined to be a low risk level. On April 18, 2023, at 7:24 a.m., the surveyor observed ULP-F administer R2's scheduled morning medications. ULP-F was hired on August 23, 2022, to provide direct care services under the assisted living with dementia care license. ULP-F's employee record included documentation of a positive tuberculin skin test (TST) with a handwritten note on the paper that indicated ULP-F was treated for TB years ago and was not authenticated by any staff. ULP-F's employee record did not include a physical examination or chest x-ray to rule out active TB by a physician after receiving a positive TST	0 660		

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0 660	Continued From page 5 reading. On April 18, 2023, at 11:20 a.m., licensed assisted living director (LALD)-A stated ULP-F's record indicated a positive TST reading and did not include a chest x-ray to rule out active TB. LALD-A stated a physical examination and chest x-ray should have been completed by a physician to rule out active TB prior to ULP-F providing services. The licensee's TB Plan, Staff Screening, Resident Assessment policy dated August 1, 2021, indicated if a staff member has a newly identified positive TST, the staff would be referred to a physician for a physical examination and chest x-ray to rule out active TB disease. Staff would not be allowed to work until the chest x-ray and physical examination are completed and active pulmonary TB disease has been ruled out. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 6 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). Findings include: On April 17, between approximately 1:30 p.m. and 2:30 p.m., survey staff toured the facility with facility director (DO)-D and licensed assisted living director (LALD)-A, it was observed the emergency egress lighting throughout the building was not operable upon testing. It was also observed that emergency exit doors going out to the courtyard had gates that were locked which removes a safe means of egress during a fire or similar emergency. These emergency exit doors were identified with overhead exit signs and are included in the facility's evacuation plan. April 17, 2023, DO-D and LALD-A verbally confirmed survey staff observations.	0 800		

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0 800	Continued From page 7 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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0 810	Continued From page 8 drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete required employee evacuation drills. This 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). Findings include: An interview and record review were conducted on April 17, 2023, between approximately 2:30 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan did not have 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; employees did not receive training twice per year after initial hire;	0 810		

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0 810	Continued From page 9 residents capable of self-evacuation were not provided training on proper actions to take in the event of a fire to include movement, evacuation, or relocation; and evacuation drills for employees had not been performed every other month as required. During interview, LALD-A stated that the facility recently let an employee go that had taken all policies and procedures with them upon termination. LALD-A also stated that they did not have all these policies and procedures replaced at the time of survey. Policies were requested the fire safety and evacuation plan requirements, employee fire safety and evacuation training, resident training, and evacuation drills, but could not be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 10 (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 employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 11 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (ULP)-F). 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: ULP-F was hired on August 23, 2022, to provide direct care services under the assisted living with dementia care license. On April 18, 2023, at 7:24 a.m., the surveyor observed ULP-F administer R2's scheduled morning medications. ULP-F's employee record did not include the following required orientation content: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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 _____	04/19/2023

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
01470	Continued From page 12 On April 19, 2023, at 1:28 p.m., licensed assisted living director (LALD)-A reviewed ULP-F's employee record and on-line training transcript. LALD-A stated ULP-F had not completed all the required content of assisted living orientation as required. The licensee's Orientation for Assisted Living Staff dated August 1, 2021, indicated direct staff must complete an orientation to assisted living including the following: -an introduction and review of the community's policies and procedures related to the provision of assisted living services by the individual staff person; and -review of the types of assisted living services the employee will be providing and the community's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by:	01550		

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01550	Continued From page 13 Based on interview and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (dietary aide (DA)-G). 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 the entrance conference on April 17, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided services to residents with dementia and other related disorders. DA-G started employment on March 2, 2007, and began providing dietary aide services under the assisted living with dementia care license August 1, 2021. DA-G's employee record lacked evidence DA-G completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On April 19, 2023, at 11:36 a.m., DA-G stated she has not completed her annual dementia training, however, the facility had offered it to her through the on-line training courses. On April 19, 2023, at 1:23 p.m., LALD-A reviewed	01550		

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01550	Continued From page 14 DA-G's employee record and on-line training transcript. LALD-A stated DA-G had not completed any annual dementia training. The licensee's Required Annual Staff Training dated August 1, 2021, indicated staff must complete annual training including effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. 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 instructions for one of two medication refrigerators by failing to monitor and document medication refrigerator temperatures. 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	01880		

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HAWLEY SENIOR LIVING	923 5TH STREET HAWLEY, MN 56549

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01880	Continued From page 15 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: On April 17, 2023, at 11:07 a.m., the surveyor reviewed the locked medication refrigerator located in the north wing laundry room with unlicensed personnel (ULP)-H. ULP-H stated the current refrigerator temperature was 39 degrees Fahrenheit (F). The refrigerator included the following medications: -9 unopened Novolog 100 units/milliliters (mL) insulin pens for R2 -4 unopened Novolog 100 units/mL insulin pens for an unidentified resident -17 unopened Lantus 100 units/mL insulin pens for an unidentified resident On April 17, 2023, at 11:07 a.m., the daily medication refrigeration log sitting on the top of the medication refrigerator was reviewed with licensed assisted living director (LALD)-A and she confirmed the temperature was not being logged daily, however thought the temperature was being recorded in the electronic record. On April 17, 2023, at 12:41 p.m., review of the Electronic Chore Recap by Specific Chore for the Fridge Temp (temperature) was reviewed with LALD-A and confirmed from April 1, 2023, through April 16, 2023, two (2) out of 16 opportunities the medication refrigerator temperature was logged. LALD-A stated the refrigerator temperature should be logged daily.	01880		

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01880	Continued From page 16 The manufacturer's instructions for Novolog dated March 2021, indicated before opening store the pen in the refrigerator (36-46 degrees F). Do not allow Novolog to freeze. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The licensee's Storage of Medication policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 maintained with the original prescription label for one of three residents (R6). In addition, the licensee failed to ensure medications were	01890		

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01890	Continued From page 17 maintained with legible information including the expiration date for time sensitive medications for one of three residenst (R5) and failed to monitor for expired medications for one of three residents (R4) and the licensee's stock medications. 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: During the entrance conference on April 17, 2023, at 10:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. ORIGINAL PRESCRIPTION LABEL On April 17, 2023, at 10:58 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-H including a reviewed of the North wing locked medication cart. In the locked narcotic box of the medication cart contained an unlabeled clear baggie of 10 syringes filled to 0.1 milliliters (mL) of liquid. ULP-H stated the syringes contained Morphine for R6 that hospice set up. On April 17, 2023, at 11:47 a.m., CNS-B stated the 10 syringes in the baggie were Morphine for R6 and hospice had set up the syringes. CNS-B stated the syringes did not bear an original prescription label including the prescription	01890		

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01890	Continued From page 18	01890		

number, residents name, name of the medication, dosage, amount to administer, and how often the medication can be administered. CNS-B stated the baggie of syringes should have been labeled with the above content. CNS-B provided to the surveyor at a later time documentation of the medication set up from the hospice nurse.

DATING TIME SENSATIVE MEDICATIONS
On April 17, 2023, at 10:54 a.m., the surveyor reviewed the North wing medication cart with LALD-A and ULP-H and confirmed the following:

R5's Lantus 100 units/mL pen (a multiple dose pen shaped injector device for insulin administration) had a label from the pharmacy to indicate when the insulin pen was opened, however, it was not filled in.

On April 17, 2023, at 10:54 a.m., ULP-H confirmed the pen was not labeled with the open date and was not sure when the pen was opened.

On April 17, 2023, at 11:44 a.m., CNS-B stated insulin pens come with a label to indicate the open and expiration date, but staff should make sure the label is filled out when opening the pen.

The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it.

EXPIRED MEDICATIONS
On April 17, 2023, at 10:54 a.m., the surveyor reviewed the North wing medication cart with LALD-A and ULP-H and confirmed the following:
-R4's opened osteomatrix supplement with approximately half the bottle remaining expired

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01890	Continued From page 19 December 2022; -R4's opened B Complex supplement with approximately half the bottle remaining expired April 2021; and -R4's opened Omega Guard fish oil supplement with approximately one fourth the bottle remaining expired December 2022. On April 17, 2023, at 11:23 a.m., the surveyor reviewed the middle wing medication cart with LALD-A and ULP-I and confirmed the following: -opened stock supply miralax 17 grams with approximately half the bottle remaining expired January 2022; -opened stock supply ibuprofen 200 mg with approximately one fourth of the bottle remaining expired February 2023; and -opened stock supply glucose tablets with approximately one fourth of the bottle remaining expired January 2023. On April 17, 2023, at 11:31 a.m., the surveyor reviewed the South wing medication cart with LALD-A and ULP-J and confirmed the following: -opened stock supply aspirin 81 mg with approximately one fourth of the bottle remaining expired September 2022. On April 17, 2023, at 11:44 a.m., CNS-B stated staff should be checking for expired medications weekly. The licensee's Medication Administration-Procedure policy dated August 1, 2021, indicated all medications will have a legible and neat label. If you cannot read the label, stop and call the licensed practical nurse (LPN)/registered nurse (RN) for instructions. The licensee's Storage of Medications policy	01890		

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01890	Continued From page 20 dated August 1, 2021, indicated medications need to be labeled and dated with the open date, expiration date, if applicable. The licensee's Disposal of Medication policy dated August 1, 2021, indicated expired medications managed by the licensee will be disposed of according to the accepted practices and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who reside in the facility with regards to safely storing chemicals and sharp objects. This had the potential to affect all 33 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	02310		

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02310	Continued From page 21	02310		

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:

The licensee held an assisted living with dementia care license.

On April 17, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided services to residents with dementia and other related disorders.

On April 17, 2023, from 10:50 a.m. through 11:47 a.m., the surveyor toured the entire facility with LALD-A. The facility layout was one whole memory care unit (a secured unit requiring a key code to enter and exit), which included one long hall way divided into two separate wings (South wing and middle wing) and an additional hallway adjacent to the middle wing (North wing).

STORAGE OF CHEMICALS
On April 17, 2023, at 11:06 a.m., the surveyor toured the facility with LALD-A which included the beauty salon. LALD-A opened the beauty salon door that was not locked and inside the beauty salon on the shelf contained several different chemicals including glass cleaner, clippercide isopropyl 45.6 percent, salon care disinfectant, Lysol and a multi surface cleaner.

On April 17, 2023, at 11:07 a.m., LALD-A stated the door should have been locked, so residents did not have access to the chemicals.

STORAGE OF SHARP OBJECTS
On April 18, 2023, at 10:00 a.m., the surveyor

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02310	Continued From page 22	02310		

entered the nurse's station, which did not have a door, located in the middle wing at the end of the hallway with ULP-E. Inside the nurse's station was a small round table which had two retractable utility knives, one pair of scissors, and one screwdriver sitting on top of the table. A file cabinet in the nurse's station, located in the wall, was not locked and in the third drawer down contained a pair of scissors. ULP-E confirmed the above findings and removed all sharp objects from the area. ULP-E stated residents would be able to access the nurse's station at any time.

On April 18, 2023, at 10:09 a.m., LALD-A stated the above items should not have been left in the nurse's station and should have been stored securely in the medication cart or maintenance room.

On April 18, 2023, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated a scissor, utility knife and screwdriver could have been used as a weapon. CNS-B stated the two utility knives, two pair of scissors, and the screwdriver should have been stored in a secured area that residents would not have access too.

The licensee's undated Laundry Room/Chemical Room policy indicated staff should routinely check that chemicals are stored securely away from the resident's ability to reach and the door will remain closed and locked while not occupied.

The licensee's Clean and Safe Environment dated August 1, 2021, indicated for staff to be alert for sharp objects and remove if indicated.

No further information provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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02310	Continued From page 23 days	02310		

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

Type: Full
Date: *04/17/23*
Time: 11:04:38
Report: 7935231064

Food and Beverage Establishment Inspection Report

Location:
Hawley Senior Living
923 5th Street
Hawley, MN56549
Clay County, 14

Establishment Info:
ID #: 0038919
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184833337
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 176 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

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

Type: Full
Date: *04/17/23*
Time: 11:04:38
Report: 7935231064
Hawley 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 MN Department of Health inspection report number 7935231064 of 04/17/23.

Certified Food Protection Manager: Tanda Thorson

Certification Number: 2688 Expires: 05/25/23

Signed: _____ Signed: 7935

Establishment Representative

7935

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