Electronically Delivered

August 12, 2026

Licensee
Hadley House
908 Coney Street West
Perham, MN 56573

RE: Project Number(s) SL31560016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 2026, 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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 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

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.

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31560	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL39843016-0 On July 20, 2022, through July 22, 2022, 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 29 resident(s); all 29 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living with dementia care license and was licensed for a capacity of 32 residents, with a current census of 29 residents. During the entrance conference on July 20, 2026, at 10:55 a.m., licensed assisted living director (LALD)-B stated a staffing plan has not been reviewed by her and the clinical nurse supervisor (CNS) and stated she has been doing this for many years and knows how many staff are needed. In addition, LALD-B stated the licensee's staffing schedule was as follows: - day shift - one unlicensed personnel (ULP) from 6:00 a.m. to 2:30 p.m., and one ULP from 7:00 a.m. to 3:30 p.m.; - evening shift - one ULP from 2:30 p.m. to 11:00 p.m., and one ULP from 3:30 p.m. to 12:00 a.m.; and - night shift - one ULP from 11:00 p.m. to 7:00 a.m. The licensee's Staffing & Scheduling policy dated January 12, 2025, noted the CNS would develop and implement a written staffing plan to provide an adequate number of staff to meet the residents' needs. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 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	0 480		

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0 480	Continued From page 4 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: 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:	0 480		

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 27, 2026, 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 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make menus available to residents at least one week in advance. This had the potential to affect all current residents.	0 485		

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0 485	Continued From page 6 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on July 20, 2026, at 11:45 a.m., the surveyor observed the facility to be a one level building with a main entrance, office spaces, dining room, and kitchen in the center, and resident rooms down both hallways, with sitting areas at the end of each hallway. The surveyor observed the menu posted near the entrance to the dining room for the current week. The licensee failed to ensure menus were prepared at least one week in advance and made available to all residents. On July 22, 2026, at 10:05 a.m., licensed assisted living director (LALD)-B stated the menu was only posted for the current week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who	0 550		

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0 550	Continued From page 7 are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect the licensee's current 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, 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: During the facility tour on July 20, 2026, at 11:45 a.m., the surveyor observed the facility to be a one level building with a main entrance, office spaces, dining room, and kitchen in the center,	0 550		

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0 550	Continued From page 8 and resident rooms down both hallways, with sitting areas at the end of each hallway. The postings were noted near the front entryway. On July 22, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the posted complaint policy lacked the required contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on	0 660		

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0 660	Continued From page 9 the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test and a screening for symptoms or history of TB for one of three employees (unlicensed personnel/ULP-E). 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 licensee's Facility TB Risk Assessment dated April 29, 2026, indicated the licensee was a low risk. ULP-E was hired on March 9, 2026, to provide direct care and services to the licensee's residents. ULP-E's record contained a one-step TST dated read on February 27, 2026. However, the record lacked: - TB history and symptom screening; and - second-step TST. On July 21, 2026, at 10:32 a.m., registered nurse (RN)-D stated a second step TST had yet to be completed for ULP-E as required, and the record was missing the history and symptom screening. The licensee's Tuberculosis policy dated March	0 660		

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0 660	Continued From page 10 20, 2024, noted the RN would assess all new employee's TB history, and a two-step TST would be completed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, it noted TST documentation should include the date of the test, the number of millimeters (mm) of induration (if no induration, document "0" mm) and the interpretation (positive or negative). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 11 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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, 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 facility tour on July 20, 2026, at 11:45 a.m., the surveyor observed the facility to be a one level building with a main entrance, office	0 680		

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0 680	Continued From page 12 spaces, dining room, and kitchen in the center, and resident rooms down both hallways, with sitting areas at the end of each hallway. The licensee's red binder labeled Emergency Preparedness was located near the front entrance and the white Binder titled Emergency Plan for Continuity of Care and Disaster Preparedness was located in the medication room with the "go bag". The binders lacked a date when reviewed. The binders also lacked: - hazard vulnerability risk assessment; - quarterly review of the missing resident plan; - primary and alternate means of communication with external sources of assistance; - policy and procedure to address the system of medical documentation that preserves resident information, protects confidentiality, and secures and maintains availability of records; - signed arrangements with other facilities or providers to receive residents in the event of limitations or cessation of operations to maintain continuity of services to residents; - policy and procedure to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act; - communication plan including contact information with: - Federal, State, tribal, regional and local emergency preparedness staff; - State licensing and certification agency; - Minnesota Office of Ombudsman for Long-Term Care; and - other sources; - communication plan including - the primary and alternate means of communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies; and	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31560	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOUSE	908 CONEY STREET WEST PERHAM, MN 56573

(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
0 680	Continued From page 13 - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families / representatives; - emergency plan training and testing program; and - exercises to test the emergency plan at least twice per year, including unannounced staff drills. On July 22, 2026, at 9:15 a.m., licensed assisted living director (LALD)-B and owner (O)-C stated the registered nurse had been working on the plan, but were not sure when it had last been fully reviewed, including the hazard vulnerability risk assessment. In addition, they stated the missing resident plan was reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 14 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R1) who was hospitalized. 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	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOUSE	908 CONEY STREET WEST PERHAM, MN 56573

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01060	Continued From page 15 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: R1's diagnoses included Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), acute myocardial infarction/heart attack (blood flow to part of the heart muscle is blocked, causing tissue damage or death), and hypertension (high blood pressure). R1's Service Plan dated July 16, 2026, indicated R1 received services including assistance with bathing, compression stockings, grooming, and blood glucose checks. R1's Resident Notes included the following: - July 14, 2026, at 10:38 p.m., R1 was taken to the emergency room by family after noting his face looked droopy, and he started to fall after getting out of bed; - July 15, 2026, at 12:26 a.m., hospital staff notified the licensee R1 had been admitted to the hospital; and - July 16, 2026, at 1:59 p.m., R1 returned to the facility at 11:45 a.m. On July 22, 2026, at 9:50 a.m., licensed assisted living director (LALD)-B stated the licensee had the form to use, but she was unsure if nursing had been completing them or not. No further information provided.	01060		

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HADLEY HOUSE	908 CONEY STREET WEST PERHAM, MN 56573

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01060	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01565 SS=C	144G.64 (c) Training in Dementia, Mental Illness, and De- (a)The facility shall provide to consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living license effective April 1, 2026, through March 31, 2027. The licensee's Dementia - Training for Employees and Notice of Services policy dated	01565		

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01565	Continued From page 17 July 28, 2021, lacked the basic topics covered to include: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting crisis response teams and 988 suicide and crisis lifelines. On July 20, 2026, at 11:20 a.m., licensed assisted living director (LALD)-B stated the disclosure did not include the mental health topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01565		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 18 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2). 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: R1 R1's diagnoses included Type II diabetes (high blood sugar caused from the body resisting insulin or failing to produce enough insulin), acute	01650		

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01650	Continued From page 19 myocardial infarction/heart attack (blood flow to part of the heart muscle is blocked, causing tissue damage or death), and hypertension (high blood pressure). R1's Service Plan dated July 16, 2026, indicated R1 received services including assistance with bathing, compression stockings, grooming, and blood glucose checks. However, it lacked: - the schedule and methods of monitoring staff providing services. R2 R2's diagnoses included progressive multifocal leukoencephalopathy (a rare, severe viral brain infections), ataxia (a lack of voluntary muscle coordination), and cerebral palsy (abnormal muscle tone, movement, and coordination). R2's Service Plan dated April 1, 2026, indicated R2 received services including assistance with bathing, dressing, grooming, and medication administration. However, it lacked: - the schedule and methods of monitoring staff providing services; and - identification of and information as to who has authority to sign for the resident in an emergency. On July 22, 2026, at 9:50 a.m., licensed assisted living director (LALD)-B stated the required content was all included on the previous service plans, but evidently had not been transferred over to the new electronic record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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02310	Continued From page 20	02310		
02310 SS=D	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 care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with hospital bed rails. 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: R2's diagnoses included progressive multifocal leukoencephalopathy (a rare, severe viral brain infections), ataxia (a lack of voluntary muscle coordination), and cerebral palsy (abnormal muscle tone, movement, and coordination). R2's Service Plan dated April 1, 2026, indicated R2 received services including assistance with bathing, dressing, grooming, and medication administration.	02310		

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02310	Continued From page 21 On July 22, 2026, at 10:20 a.m., the surveyor observed R2's bed rails with registered nurse (RN)-D to be a hospital style bed with hospital bed rails in the raised position on both sides of the bed. The bed rails were metal material with six vertical bars between the entire bed rail frame. There was a horizontal bar between the bed rail frame and the second inside rail on both ends, making the outermost inside rail shorter. RN-D measured the bed rail as follows: - zone 1 (within the rails) from 3 inches to 4.25 inches; - zone 2 (under the rail, between the rail supports or next to a single rail support) 0 inches; - zone 3 (between the rail and the mattress) 1.5 inches; and - zone 4 (under the rail, at the ends of the rail) 0 inches. R2's Assessment dated June 30, 2026, noted "The bed rail is 4.25 inches between gaps/rails. It is a 18 inch tall bilateral rail's (sic) that are 32 inches long there is a 1.5 inch gap between rail and mattress. It meets FDA guidelines and Residents or family members were given requirements and safety risks to have bed rail in facility. They are checked for stability every 90 days by RN." R2's record lacked documentation complete measurements of the bed rails. On July 22, 2026, at 10:32 a.m., RN-D stated the assessment lacked the complete measurements for zone one and lacked any measurements for zones two and four. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated	02310		

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02310	Continued From page 22 December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Bed rail measurements; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 23 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HADLEY HOUSE
908 Coney Street West
Perham, MN 56573
Otter Tail County
Parcel:

Phone:

License Info

License: HFID 31560

Risk:
License:
Expires on:
CFPM: Linda M. Przepiora
CFPM #: 93649; Exp: 04/19/2027

Inspection Info

Report Number: F1065261082
Inspection Type: Full - Single
Date: 7/22/2026 Time: 10:30:14 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-204.11 *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.
COMMENT: THE HOOD BAFFLES HAD A BUILD UP OF DUST AND GREASE AT THE TIME OF INSPECTION. DISCUSSED A MORE FREQUENT CLEANING SCHEDULE TO PRECLUDE THIS BUILD UP.
Comply By: 7/22/2026 Originally Issued On: 7/22/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: QUATERNARY AMMONIA TEST STRIPS ARE NEEDED - THE FACILITY ONLY CURRENTLY HAS CHLORINE STRIPS. DISCUSSED WITH THE OPERATOR.
Comply By: 7/29/2026 Originally Issued On: 7/22/2026

Food & Beverage General Comment

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.

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 F1065261082 from 7/22/2026

Monique Erickson

Establishment Representative

Monique Erickson,
Public Health Sanitarian 2
218-332-5146
monique.erickson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537

Temperature Observations/Recordings

Establishment Info

HADLEY HOUSE
Perham
County/Group: Otter Tail County

Inspection Info

Report Number: F1065261082
Inspection Type: Full
Date: 7/22/2026
Time: 10:30:14 AM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Ambient Air
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537

Sanitizer Observations/Recordings

Establishment Info

HADLEY HOUSE
Perham
County/Group: Otter Tail County

Inspection Info

Report Number: F1065261082
Inspection Type: Full
Date: 7/22/2026
Time: 10:30:14 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 162.5 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No