Electronically Delivered

March 13, 2024

Licensee
Hadley House
908 Coney Street West
Perham, MN 56573

RE: Project Number(s) SL31560015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, 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 . . ."

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. 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

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

PMB

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 _____	02/22/2024

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
0 000	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: SL31560015 On February 20, 2024, through February 22, 2024, 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 25 residents receiving services under the Assisted Living 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 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 appropriate hand hygiene, following glove removal for treatment administration for one of one 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: On February 20, 2024, at 12:00 p.m., surveyor observed ULP-F obtain resident's (R1) blood sugar. After completing blood sugar, ULP-F removed gloves, did not perform hand hygiene, and proceeded to don (putting on gloves) another pair of gloves to administer insulin. When surveyor asked about hand hygiene expectations	0 510		

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0 510	Continued From page 2 following removal of disposable gloves, she stated we are to wash our hands or use hand sanitizer. ULP-F then proceeded to use hand sanitizer hung outside resident's door, performed hand hygiene with hand, sanitizer and proceeded to don gloves to administer insulin. On December 20, 2024, at 12:07 p.m., registered nurse (RN)-D stated staff are trained to wash hands or use hand sanitizer after removing gloves and she may have been nervous as someone was watching. ULP-F's blood glucose monitoring training dated June 21, 2023, signed by ULP-F and RN-D indicated following disposing of gloves, staff are to wash hands. The licensee's undated Handwashing Technique Policy and Procedure indicated times to wash your hands include: when arriving to work, before medication administration, before walking into a clients room, before any client care, before switching from one client care to the next (even on the same client), after client cares, before you don gloves, after removing gloves, after toileting a client, after you use the toilet, before you eat or feed someone else, after you empty the garbage can, after you cough, sneeze or blow your nose, after anything that involves bodily fluids or another person's or any time you are just unsure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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

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0 650	Continued From page 4 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-G was hired on February 13, 2023, to provide direct care services to residents of the assisted living facility. On February 21, 2024, at 7:54 a.m., surveyor observed ULP-G administer scheduled oral medications, perform a blood sugar check, and administer insulin. ULP-G's employee record lacked documentation of registered nurse (RN) training and competency for unplanned times away medication set-up for residents when no licensed nurse is available. On February 21, 2024, at 9:30 a.m., RN-D stated ULP-G was trained on the policy and procedure for unplanned time away medication set-up on February 13, 2023. Additionally, RN-D stated the licensee made up new competency documents and the licensee is in the process of updating older employee files that were hired prior to July 2023. The licensee's Orientation, Training, and Competency Evaluation [facility name] policy and procedure reviewed on July 28, 2021, indicated documentation of orientation will be located in the employee personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 5	0 660		
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 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). The licensee failed to complete a tuberculosis (TB) history and symptom screening for one of three employees (unlicensed personnel (ULP)-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	0 660		

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0 660	Continued From page 6 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 May 24, 2023, and was determined to be a low risk level. ULP-G was hired on February 13, 2023, to provide direct care services to the licensee's residents. ULP-G's employee record included documentation of a negative QuantiFERON (a blood test used to see whether a person has been infected with the bacteria causing TB) on February 20, 2023. ULP-G's record did not include a completed TB history and symptom screening. On February 21, 2024, at 3:15 p.m., employee manager (EM)-C stated the TB history and symptom screening was not completed, she assumed the clinic would have completed the screening prior to the TB blood test. The licensee's undated Mantoux policy and procedure indicated all new employees are required to be screened and tested for TB. The training registered nurse (RN) will do an assessment checking for current symptoms for active TB disease and will assess the new employees' TB history. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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0 730	Continued From page 7	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 8 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R3) discharged from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 Discharge Resident/Client Roster indicated R3 was admitted on June 5, 2023, and was discharged on January 23, 2024. R3's diagnoses included hypertension (HTN), depression and atrial fibrillation (irregular heartbeat). R3's service plan dated June 5, 2023, indicated R3 received the following services: medication management, safety checks, assistance with showering, housekeeping and laundry.	0 730		

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0 730	Continued From page 9 R3's progress note dated January 14, 2023, documented by employee manager (EM)-C, "[name] from [facility] called today at approximately 3:40 p.m., licensed assisted living director (LALD)-A and this staff, (EM-C) received update. Resident seen orthopedic today, continues non-weight bearing status. Has walker with handheld assist with therapy only 80 feet. Extensive assist with all dressing and toileting, they feel [resident's name] will never be independent with cares again. [Resident name] is able to sit on the edge of the bed by herself. [Resident name] has been a Hoyer lift and has had one fall to date for them on Thursday December 28, 2023. On January 5, 2023, [resident name] is having x-ray done and will see orthopedic again and will also see an audiologist". R3's progress notes dated January 17, 2024, documented by clinical nurse supervisor (CNS)-B, Concern: Discharge, "EM-C received a call today from [company name] that they were sending someone to evaluate how much stuff [resident name] has for moving. They said she will be having movers move her stuff. This writer called [name] the social worker at [facility] to find out more information and none was provided. This writer counted all [resident name] medications that were in the medication room. All medications packed up and sealed in a box waiting to pick up. All medications and count filled out on medication destruction sheets. [Name] came to assess things for moving." R3's progress notes dated January 19, 2024, documented by CNS- B, Concern: General, "[name] the case worker for [resident name], came to pick up her medications and her mail."	0 730		

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0 730	Continued From page 10 R3's progress notes dated January 24, 2024, documented by CNS- B, Concern: Discharged out, "Movers came today and moved all of [resident name] new stuff to the new facility she is moving to. This writer went through room with movers afterward and they did remove all items." R3's record lacked a discharge summary with required content to include: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments, and therapies, pertinent lab, radiology, and consultations reviews; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status; and -post discharge plan that is developed with the resident and, with the residents' consent, the residents' representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident may need. On February 21, 2024, at 1:29 p.m., registered nurse (RN)-D stated a discharge summary with required content was not completed, however did have a medication disposition of medications to include over the counter medications. Additionally, RN-D stated she was confused what information needed to be included. Surveyor reviewed Minnesota Rules Chapter 4659.0160, subdivision 9, resident discharge summary with RN-D.	0 730		

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0 730	Continued From page 11 Minnesota Rules - Assisted Living Facilities 4659.0120 Procedures for Resident Termination and Discharge Planning, subdivision 9, Resident discharge summary, indicated each facility must provide the resident, and, with the resident's consent, the resident's representative, and case manager with a written discharge summary. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This	0 790		

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0 790	Continued From page 12 deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 20, 2024, at 11:15 a.m., survey staff conducted a facility tour with owner (O)-E, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. O-E stated he did not know that the fire extinguishers needed to be inspected monthly. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 810		

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	31560	A. BUILDING: _____ B. WING _____	02/22/2024

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0 810	Continued From page 13 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 drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required 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	0 810		

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0 810	Continued From page 14 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: A record review and interview were conducted on February 20, 2024, at 12:10 p.m., with owner (O)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute.	0 810		

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0 810	Continued From page 15 During interview, O-E verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 16 registered nurse (RN) conducted a comprehensive assessment using a uniform assessment tool after a change in condition for one of two residents (R1). 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: R1's diagnoses included diabetes, hypertension (high blood pressure), and hyperglycemia (high blood sugar). R1's Service Plan dated March 31, 2023, indicated R1 received medication management, blood sugar checks, assistance with bathing, nail care, and skin care, housekeeping, and laundry. On February 21, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R1's morning medications, insulin, and check blood sugar. R1's progress notes dated December 26, 2023, documented by clinical nurse supervisor (CNS)-B, Concern: Hospitalized, "This writer was informed that [resident name] went unconscious at church with his family on Christmas Eve. He was transported by ambulance to [hospital]. Sometime over the weekend he was transported to [hospital] in [city]. Today this writer talked to case manager who said he presented with left	01620		

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01620	Continued From page 17 facial droop but that has recovered. He was evaluated for a pacemaker and that was ruled out. They are going to run more tests." R1's progress notes dated December 26, 2023, documented by CNS-B, Concern: Return, "[Resident name] returned from the hospital. His daughter said they did note a transient ischemic attack (TIA). He has new metoprolol order, therapy orders and an order for a heart monitor to be placed when he goes to the provider. Montreal Cognitive Assessment (MoCA) (rapid screening instrument for mild cognitive dysfunction) done in hospital, score 14/30. Will continue to monitor." R1's record lacked a comprehensive assessment following a hospital stay. On February 21, 2024, at 1:29 p.m., registered nurse (RN)-D stated because it was on a two day hospital stay, and not a three day stay, the licensee could wait and do the change of condition assessment in 14 days and was unaware the assessment needed to be done right away on his return from the hospital. The licensee's Initial Reviews, Assessments and Monitoring policy dated August 2, 2023, indicated monitoring and review will be conducted as needed based on changes and the needs of the resident and will not exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		

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01640	Continued From page 18	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was updated for one of one resident (R1). 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	01640		

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01640	Continued From page 19 situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), and hyperglycemia (high blood sugar). R1's prescriber orders dated November 28, 2023, included insulin Humalog 200 units/milliliter (ml) 3 units every meal and sliding scale subcutaneously (sq) for blood glucose < 60 milligram (mg)/per deciliter (dl), hypoglycemia management and call physician. Blood sugar (BS) < 140: hold, BS 150-199 4 units; BS 200-249 6 units; BS 250-299 8 units; BS 300-349 10 units; BS > 349 12 units; BS > than 400 inform registered nurse (RN) to call medical provider. Lantus 100 units/ml 60 units every day in the morning. On February 21, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R1's morning medications, scheduled and sliding scale insulin, and check blood sugar. R1's Service Plan dated March 31, 2023, lacked evidence R1 received administration of sliding scale insulin. On February 21, 2024, at 2:16 p.m., registered nurse (RN)-D and surveyor reviewed R1's service plan and RN-D stated the insulin sliding scale was not added to his service plan, Additionally, RN-D stated the sliding scale was ordered when she was on medical leave, it must have been missed. The licensee's Service Plan Implementation and	01640		

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01640	Continued From page 20 Revisions policy, dated August 3, 2023, indicated the service plan may be revised, if needed, based on the resident assessment under subdivision 2. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel/ULP-F, ULP-G) followed the medication administration preparation and documentation process for resident (R1). 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	01760		

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01760	Continued From page 21 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnosis included diabetes, hypertension (HTN) and hyperglycemia (high Blood sugar). R1's service plan dated March 1, 2023, indicated R1 received medication management, blood glucose checks, assistance with bathing, grooming, vitals, housekeeping, and laundry. R1's prescriber orders dated March 29, 2023, included insulin Humalog 200 units/milliliter(ml) 3 units every meal; and sliding scale subcutaneously (sq) for blood sugar (BS) less than 60 milligram (mg)/per deciliter(dl), call medical provider; BS less than 140, hold; BS: 150-199 4 units; BS: 200-249: 6 units; BS: 250-299: 8 units; BS 300-349: 10 units; BS greater than 349: 12 units; BS greater than 400 inform registered nurse (RN) to call medical provider. ULP-F On February 20, 2024, at 12:00 p.m., surveyor observed ULP-F administer R1's scheduled lunch time Humalog 200 units/ml, 3 units, plus 4 units sliding scale sq in left side of abdomen (blood sugar, 169). ULP-F documented (initialed) on medication administration record (MAR) Humalog 3 units administered, documented blood sugar, and initialed sliding scale given. ULP-F failed to	01760		

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01760	Continued From page 22 document number of units of Humalog sliding scale given. ULP-D stated some people document the number of units and some do not and does not remember being trained to document the units. On December 20, 2024, at 12:07 p.m., registered nurse (RN)-D stated ULPs are trained to document number of units given when sliding scale is administered. R1's February 2024, MAR lacked documentation of Humalog sliding scale units given on the following dates and times: -8:00 a.m., February 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20; -12:00 p.m., February 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15, 16, 17, 18, 19; and -5:00 p.m., February 5, 11. ULP-F's Insulin Administration - Pen competency dated June 21, 2023, indicated to document the administration, dose (if sliding scale), injection site, and blood glucose results. ULP-G On February 21, 2024, at 7:54 a.m., surveyor observed ULP-G prepare R1's Humalog 200 units/ml insulin by removing the pen cap, then placed a needle shield onto the pen. Surveyor asked ULP-G if she was missing a step in the prep of insulin pen, she was not aware of anything she missed. Clinical nurse supervisor (CNS)-B, ULP-G and surveyor reviewed insulin packing insert found in R1's insulin pens. CNS-B stated they are trained to do this prior to placing needle shield on insulin pen. ULP-G indicated not remembering being trained that way. ULP-G's competency training dated February 15,	01760		

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01760	Continued From page 23 2023, indicated ULP-G demonstrated ability to prep and prime the insulin pen. The Humalog insulin pen manufacturer directions dated 2023, indicated once the pen cap is removed to wipe the rubber seal with an alcohol swab before capping with a needle shield. The licensee's undated Administration of Medications Minnesota (MN) Statute 144G.71 Subd. 6 & Policy and Procedure, indicated ULPs who have been trained and delegated the task of medication and/or treatments, are responsible for the administration, documentation, follow-up, and updates to the RN as needed. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

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01940	Continued From page 24 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (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 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 January 20, 2024, at 9:00 a.m., during entrance conference, clinical nurse supervisor (CNS)-C stated the licensee provided treatments and therapy services to residents. R2's diagnosis included asthma (airways narrow	01940		

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01940	Continued From page 25 and swell), coronary artery disease (decreased blood supply to coronary arteries), and congestive heart failure (left sided heart failure). R2's service plan dated November 29, 2023, indicated unlicensed personnel (ULP) to assist with compression stockings twice a day. R2's prescriber orders dated May 17, 2023, included to continue to wear compression stockings. On February 21, 2024, at 8:10 a.m., surveyor observed ULP-G administer R2's scheduled morning medications and apply compression stockings. On February 21, 2024, at 8:17 a.m., ULP-G could not find compression stockings on treatment administration record (TAR) to document. ULP-G and surveyor spoke with clinical nurse supervisor CNS-B, and CNS-B stated she could not find the compression stockings treatment on the TAR, nor was it on the delegated task list. R1's record lacked an Individualized Treatment and Therapy plan to include the following: - documentation of specific resident instructions relating to the treatment or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions.	01940		

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01940	Continued From page 26 The licensee's Documentation of Administration of Treatment and Therapy policy dated July 28, 2021, indicated the RN will implement and develop the residents TAR that will list the treatment or therapy to be administered and will include: specific instructions for the treatment of therapy, frequency of the treatment or therapy, route of the treatment or therapy, time of the treatment or therapy, days of the month with the sign off for the staff to fill in once the treatment are administered, and after administration of the treatment or therapy staff will sign off on the TAR that the specific treatment or therapy has been administered by staff using their initials. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01960		

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 _____	02/22/2024

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
01960	Continued From page 27 review, the licensee failed to ensure treatment or therapy services were documented for one of one resident (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 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 diagnosis included asthma (airways narrow and swell), coronary artery disease (decreased blood supply to coronary arteries), and congestive heart failure (left sided heart failure). R2's service plan dated November 29, 2023, indicated unlicensed personnel (ULP) to assist with compression stockings twice a day. R2's prescriber orders dated May 17, 2023, included to continue to wear compression stockings. On February 21, 2024, at 8:10 a.m., surveyor observed ULP-G administer R2's scheduled morning medications and apply compression stockings. On February 21, 2024, at 8:17 a.m., ULP-G could not find compression stockings on treatment administration record (TAR) to document. ULP-G spoke with clinical nurse supervisor CNS-B, and CNS-B stated she could not find the compression stockings treatment on the TAR, nor was it on the	01960		

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 _____	02/22/2024

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
01960	Continued From page 28 delegated task list. The licensee's Documentation of Administration of Treatment and Therapy policy dated July 28, 2021, indicated the RN will implement and develop the residents TAR that will list the treatment or therapy to be administered and will include: specific instructions for the treatment of therapy, frequency of the treatment or therapy, route of the treatment or therapy, time of the treatment or therapy, days of the month with the sign off for the staff to fill in once the treatment are administered, and after administration of the treatment or therapy staff will sign off on the TAR that the specific treatment or therapy has been administered by staff using their initials. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *02/20/24*
Time: 10:30:00
Report: 1048241033

Food and Beverage Establishment Inspection Report

Location:
Hadley House
908 Coney Street West
Perham, MN56573
Otter Tail County, 56

Establishment Info:
ID #: 0038469
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183464475
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

Quaternary Ammonia: = 300ppm at Degrees Fahrenheit
Location: Sanitizer spray bottle
Violation Issued: No

Hot Water: = at 178 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Milk- reach in cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 31 Degrees Fahrenheit - Location: Cooked chicken- reach in cooler
Violation Issued: No

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

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.

MET WITH MATTHEW JOHNSON WITH HADLEY HOUSE ASSISTED LIVING AND ANN BOSWELL NURSE SURVEYOR WITH MDH.

DISCUSSED THE FOLLOWING:
-EMPLOYEE ILLNESS POLICY AND LOG (MDH ILLNESS LOG PROVIDED)
-REPORTABLE DISEASES
-COLD HOLDING
-SUSCEPTIBLE POPULATION REQUIREMENTS

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1048241033 of 02/20/24.

Certified Food Protection Manager: Linda M Przepiora

Certification Number: 93649 Expires: 04/19/27

Signed: _____
Establishment Representative

Signed: _____
Bailey Bannon
Environmental Health Specialist
Fergus Falls District Office
bailey.bannon@state.mn.us