Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304553503M
Compliance #: HL304555718C

Date Concluded: January 5, 2023

Name, Address, and County of Licensee Investigated:
Hawley Senior Living
923 5th Street
Hawley, MN 56549
Clay County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the alleged perpetrators/ (AP)1 and (AP2), both registered nurses failed to report, assess, and monitor a change in condition. The resident experienced abnormal oxygen saturation level readings over the course of three days and was later hospitalized with respiratory failure, respiratory syncytial virus (RSV), pneumonia, and a pulmonary embolism.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility as well as the registered nurses (RN)/alleged perpetrators (AP1 and AP2) were responsible for the maltreatment. The resident's oxygen saturation levels dropped below normal range over the course of several days and facility staff contacted the on-call RN (AP1) for further guidance. AP1 failed to properly assess the resident's condition and provide guidance to unlicensed personnel (ULP) related to monitoring the resident or when to send the resident to the emergency room. The facility RN (AP2) failed to properly assess and respond to the resident's low oxygen levels.

While AP2 assessed the resident in person, two days after low oxygen saturation levels were noted, AP2 failed to act on the abnormal vital signs, presence of wheezes in the lungs, and clinical presentation of the resident. Despite unlicensed staff's concerns and outreach to the RNs (AP1 and AP2), appropriate action was not taken to address the acuity of the resident's condition, resulting in a delay of care. The resident was hospitalized for 11 days with acute respiratory failure, respiratory syncytial virus (RSV), pneumonia and a pulmonary embolism.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's primary care provider. The investigation included review of the resident's progress notes, care plan, assessments, and hospital medical records. The onsite visit included observation of resident cares and medication administration.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included type two diabetes and hypertension (high blood pressure). The resident's service plan included assistance with bathing, medication administration, and twice daily oxygen saturation monitoring. The resident's assessment indicated the resident was mostly independent but needed some cueing or reminders. The resident did not have any special respiratory equipment and oxygen levels were monitored as part of the facility's COVID-19 protocols.

During routine COVID-19 protocol checks on Saturday, unlicensed personnel (ULP)-3 noted the resident's temperature to be 98.3 degrees Fahrenheit and recalled reporting her oxygen saturation levels to be around 84%-85% (90-100% is within normal limits). ULP-3 applied supplemental oxygen to the resident and continued to check the resident's oxygen saturation levels during her shift. When the resident's oxygen saturation level did not increase after application of the oxygen, staff contacted the on-call RN (AP1) on Saturday.

The resident's record lacked documentation from AP1 regarding contact made to her about the resident on Saturday.

During routine COVID-19 protocol checks on Sunday morning, ULP-4 noted the resident's temperature to be 99.9 degrees Fahrenheit. The resident's progress notes indicated "staff reported the resident's oxygen level was running between 82-90% despite having oxygen on at 3 liters. Resident was also complaining of a cough and cold" in a phone call to AP1 on Sunday morning. The notes included that the resident wanted to leave the facility with family and the "RN instructed staff to encourage resident to stay at the ALF [assisted living facility], however, she can go out if she chooses" and staff were directed to tell the resident to come back to the facility if she continued to feel ill. The resident left with family and returned later that evening.

The resident's record only contained documentation of one phone call to AP1 received on Sunday. However, staff reported having called AP1 at least twice on Sunday. There was no documentation of follow-up on the resident's condition upon her return to the facility on Sunday evening.

On Monday, the resident continued with complaints of a productive cough, feeling ill and staff reported the resident's oxygen saturation levels at 77%. The facility RN (AP2) assessed the resident and noted the resident's temperature was 99.9 degrees Fahrenheit, and her oxygen levels were 91% on 3 Liters of supplemental oxygen. The notes from AP2's assessment indicated the resident was "feeling better but was still having some cold like symptoms including a productive cough…general fatigue, and occasional shortness of breath when she exerts herself." AP2 also noted wheezes present in the lower lobes of the resident's lungs. A covid test was completed and was negative.

AP2 faxed the resident's clinic that Monday morning at 11:26 a.m. with a request to "please advise as there is positive cases of RSV in the facility." The resident's most recent vital signs were attached to the fax, including the resident's oxygen saturation level of 77% on room air.

Clinic staff received the fax later that afternoon. The clinic staff contacted the facility after they received the fax and recommended the patient be seen that day. Facility staff told the clinic staff member that a nurse was not available to assess the patient, but an appointment had been made for the resident to be seen in the clinic the next day (Tuesday).

No further monitoring, follow up, or notes regarding the resident's condition were completed following AP2's assessment that morning. The resident's oxygen saturation levels were not documented after the Monday evening check. The resident's oxygen saturation on Monday evening was noted to be 93% on room air, despite the nurse noting earlier in the day the resident was on 3 liters of supplemental oxygen. The facility did not check or document the resident's oxygen saturation levels on Tuesday before she left for her clinic appointment.

The resident's record did not contain instructions for ULPs to reference regarding the resident's use of PRN oxygen, how many liters the resident was on, or any place for staff to document the use of PRN oxygen.

The resident arrived at her clinic appointment on Tuesday morning without the use of supplemental oxygen. Upon arrival, it was noted the resident's oxygen saturation level was 83%. Clinic staff, concerned with the resident's oxygen level reading, immediately sent the resident to the emergency room for further evaluation.

The resident's hospital record indicated during collection of the resident's history and physical assessment, the resident reported to have had a cough and shortness of breath over the last "couple weeks". The resident was hospitalized for 11 days and diagnosed with acute respiratory failure with hypoxia, respiratory syncytial virus (RSV), pneumonia, and a pulmonary embolism. The hospital records indicated when the resident discharged, she required continuous use of supplemental oxygen.

After admitting back to the facility with new orders for continuous supplemental oxygen, the facility failed to enter the orders into the resident's electronic medical record. The resident's record contained no instructions for ULPs to reference regarding the resident's use of continuous oxygen, how many liters the resident was on, or any place for staff to document the use of oxygen.

A facility onsite visit was conducted 17 days after the resident's re-admission to the facility from the hospital. The investigator observed the resident on 2 liters of supplemental oxygen and several staff members confirmed the resident was supposed to be on 2 liters of supplemental oxygen. However, the hospital discharge orders indicated the resident was supposed to be on 1 liter of oxygen at rest and 3 liters with activity.

During an interview ULP-3 stated they contacted AP1 about four times from Saturday to Sunday. ULP-3 noticed the resident's oxygen was low on Saturday morning and used an as needed (PRN) order for supplemental oxygen. ULP-3 said after application of supplemental oxygen, the resident's oxygen levels usually came back up and then they would discontinue using the PRN oxygen. However, when the resident's levels didn't get above either 84% or 85% while on the supplemental oxygen, she contacted AP1. ULP-3 stated AP1 did not provide direction to increase monitoring of the resident's oxygen levels or direction on when to send the resident to the hospital. ULP-3 stated AP1 advised staff to just "keep an eye on it". ULP-3 was concerned for the resident because she had a slight cold and "you could hear it in her chest. I was concerned about it because her oxygen is low sometimes but when we have her sitting there with oxygen on for three, four hours and it's still at 86%, I was concerned." ULP-3 stated the resident's oxygen was still low on Sunday. ULP-3 said they contacted AP1 on Sunday when the resident's family wanted to take her out of the facility. ULP-3 told AP1 they did not feel the resident's oxygen levels were stable enough for her to leave the facility. ULP-3 said AP1 did not direct staff to send the resident to the emergency room, but the call was focused on the resident's right to leave the facility. ULP-3 stated the resident did not have a portable oxygen tank and left the facility without any supplemental oxygen. When the resident returned from the outing, her oxygen levels were low, and ULP-3 believed another staff member contacted AP1 again for further guidance. ULP-3 indicated that at no point over the weekend did AP1 direct staff to increase monitoring of oxygen levels or provide guidance of when to send the resident to the emergency room. ULP-3 stated she increased the frequency of checking of the resident's oxygen levels herself since she was concerned and thought it should be checked more often.

During an interview, ULP-4 stated she reached out to AP1 twice with concerns that the resident's oxygen level was not improving despite being on supplemental oxygen. ULP-4 stated the resident had been really sleepy and had some cold symptoms on Sunday morning. ULP-4 said when she called AP1 on Sunday morning to report the low oxygen levels, AP1 directed her to put supplemental oxygen on the resident. ULP-4 stated she told AP1 that the resident was already on oxygen and still had an 82% oxygen level. AP1 then directed ULP-4 to continue monitoring the oxygen levels but no tasks or directions were entered in the resident's electronic

medical record to notify staff of when to check it or where to enter updated oxygen saturation levels. ULP-4 continued to periodically check the resident's oxygen levels and said the oxygen levels remained around 80% with the use of supplemental oxygen. ULP-4 called AP1 later that afternoon because family wanted to take the resident out and she was uncomfortable because the resident's oxygen saturation had not improved, and the resident had no portable oxygen available to use while out of the facility. ULP-4 stated AP1 focused on the resident's right to leave instead of her current health status and directed staff that they had to let the resident leave. ULP-4 said at no time did AP1 direct her to increase the frequency of checking vital signs or provide any direction of when to send the resident to the emergency room.

During an interview, AP1 stated she did not work at the facility but worked remotely as an on-call nurse. AP1 stated she had a busy weekend with calls, so her note on the resident's low oxygen levels was entered as a late entry. AP1 indicated facility staff called her on Sunday because staff did not want the resident to go out of the building with family since her oxygen levels had not been stable. AP1 was not aware of when the resident was started on oxygen or if she used oxygen at baseline, but the resident's oxygen was around 82% while on 3 liters of supplemental oxygen. AP1 stated "when we're on-call for all the assisted livings, we just have a little snapshot of the resident." AP1 stated she directed staff that they had to let the resident leave the facility for the outing and that she was not concerned with the resident's oxygen levels, as her other vital signs were normal. Since the resident did not have shortness of breath, RN1 didn't feel the resident needed to be seen by a provider because "besides the oxygen being a tich low, everything else was normal." AP1 confirmed she did not provide staff with further direction or guidance of increasing checks of oxygen saturation levels or when to send the resident to the emergency room. AP1 stated, the "only thing abnormal was her oxygen and it wasn't terribly low, and the rest of the vitals were within normal limits." AP1 said if the resident would have had a fever or other abnormal vital signs, along with the 85% oxygen saturation level, she would have recommended the resident go in for an evaluation by a physician. AP1 stated anything below 85% is generally concerning but identified that it is a "case-by-case basis" on whether someone needs to be seen.

During an interview, AP2 stated she assessed the resident in person on Monday morning. The resident had a reported oxygen saturation level of 77% on room air that morning. AP2 said the resident's oxygen was running up to 90% while on supplemental oxygen. AP2 reflected that they probably should have increased the frequency of checking the resident's oxygen. AP2 stated the wheezing noted in the resident's lungs was concerning but noted that there was RSV going through the facility at that time. AP2 felt they [AP1 and AP2] handled the situation by using supplemental oxygen to treat symptoms, just like they would have done in the hospital. The resident reported she was feeling better, so AP2 didn't feel it was urgent for the resident be seen by a provider. AP2 stated her response to the resident's low oxygen level was appropriate, as she assessed the resident in person, sent a fax to the resident's primary care provider, and made an appointment for the resident to be seen in the clinic the next day. AP2 stated a fax versus a phone call to the primary care provider was also appropriate, as that was the local clinic's preferred method of communication.

During an interview, clinic staff stated they received a fax on Monday afternoon which indicated the resident was very sleepy, complained of cough and cold symptoms and the resident's oxygen had been 77% on room air and 99% on 2 liters of oxygen. The clinic staff member indicated a concern related to oxygen levels should have been a phone call instead of a fax. The clinic staff member stated they called the facility after they received the fax but was told a nurse was not available to assess the patient. The clinic staff said due to the symptoms reported, they recommended the patient be seen that day but were told by facility staff that an appointment had already been made for the next day. The clinic staff member recalled when the resident came in the following day for her appointment, she was not wearing any oxygen and her oxygen level was 83%. The clinic staff immediately sent the resident to the emergency room due to her oxygen levels.

During an interview, the resident's primary care provider indicated that if staff were aware of active RSV cases in the facility, and the resident displayed symptoms consistent with RSV, the facility should have sent the resident in for an evaluation sooner. The primary care provider confirmed the resident was not on oxygen at baseline. The primary care provider said it should have been a red flag to staff when the resident's oxygen saturation levels remained in the 80's on oxygen, especially since the resident was not normally oxygen dependent. The provider would have expected staff to send the resident to the emergency room upon initial discovery of low oxygen levels, when the resident required supplemental oxygen, and when despite the use of oxygen, was unable to maintain oxygen saturation levels above 90%. The primary care provider further indicated the clinic would have expected a phone call regarding the low oxygen concern, not a fax, since the issue was related to the overall health status of a resident.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or

maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrators interviewed: Yes

Action taken by facility:
None

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Clay County Attorney
Hawley City Attorney
Hawley Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL304553503M, HL304555718C On November 22, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL304553503M, HL304555718C, tag identification 0330, 0620, 1470, 1620, 1650, 1940, 1950, 1960, 2320, 2360, 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the surveyor access to all requested records and information necessary for the investigation. This had the potential to affect all 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) and was 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). Findings Include: On November 28, 2022, at 12:35 p.m., the surveyor requested via email to licensed assisted living director (LALD)-A to review the personnel record for registered nurse (RN)-F. On November 30, 2022, at 8:54 a.m., the surveyor requested via email to LALD-A the personnel record for RN-F be emailed by noon. LALD-A replied via email that she was still working with corporate offices to obtain RN-F's	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 330	Continued From page 2 personnel record. On November 30, 2022, at 12:20 p.m., the surveyor spoke with LALD-A on the phone to inquire about the status of RN-F's personnel record. LALD-A stated she was still working to obtain it. As of December 2, 2022, personnel records for RN-F have not been provided to the surveyor. TIME PERIOD TO CORRECT: Two (2) days.	0 330		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with a change in condition. 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	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 3 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 failed to immediately report to the provider a change in condition for R1, resulting in a delay of care. Two facility registered nurses (RN-B and RN-F) failed to appropriately assess R1's change in condition and respond to reports of oxygen saturation levels below normal ranges. R1 experienced oxygen saturation levels around 80% (normal range is 90%-100%) for three days, October 22, October 23, October 24, 2022. Unlicensed personnel (ULP)-D and ULP-E reported abnormal oxygen saturation levels to RN-F on October 22 and October 23, 2022. RN-B assessed R1 in person on October 24, 2022, with noted abnormal findings. The abnormal oxygen saturation levels were not immediately reported to a physician until mid-afternoon on October 24, 2022, and the resident was not sent in for further care until October 25, 2022. The resident was sent to the emergency room from the clinic appointment due to low oxygen saturation levels. The licensee failed to investigate the incident or report it to MAARC, even after a complaint investigation was initiated by the Minnesota Department of Health. R1's diagnoses included type two diabetes and hypertension (high blood pressure). R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 4 The resident's progress notes indicated on October 23, 2022, the resident had a temperature of 99.9 degrees Fahrenheit that morning. The resident's progress notes indicate RN-F was called October 23, 2022, and "staff reported the resident's oxygen level was running between 82-90% despite having oxygen on at 3 liters. Resident was also complaining of a cough and cold." The resident was wanting to go out of the facility with family and the "RN instructed staff to encourage resident to stay at the ALF [assisted living facility], however, she can go out if she chooses." The note indicated staff were to tell the resident to come back to the facility if she continued to feel ill. A progress note entered by RN-B on October 24, 2022, indicated she had assessed the resident in person due to a report of the resident not feeling well and experiencing cold like symptoms over the weekend. The progress note indicated the resident was "feeling better but was still having some cold like symptoms including a productive cough ...general fatigue, and occasional shortness of breath when she exerts herself." RN-B's progress note indicated wheezes in R1's lower lung lobes were present. The resident's oxygen was 91% on 3 liters of oxygen and had a temperature of 99.3 degrees Fahrenheit. A covid test was completed, which was negative. R1's record contained a fax that was sent to the resident's primary care provider at the local clinic on October 24, 2022, at 11:26 a.m. The fax asked the provider to "please advise as there is positive cases of RSV in the facility." A copy of the resident's most recent vital signs was included, including the resident having a 77% oxygen saturation on room air.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 5 A progress note entered on October 24, 2022, at 3:28 p.m. by RN-B indicated an appointment was made for R1 to be seen in the clinic on October 25, 2022. The resident's hospital records indicated the resident was sent to the emergency room on October 25, 2022, after having low oxygen levels at a clinic visit. The resident's history and physical indicated the resident had a cough over the last two to three weeks and reported having shortness of breath for a couple of weeks. The resident was hospitalized for 11 days and diagnosed with acute respiratory failure with hypoxia, RSV (respiratory Syncytial virus) pneumonia, and a pulmonary embolism. The hospital records indicated the resident was not on supplemental oxygen prior to her admission to the hospital. On November 17, 2022, at 10:15 a.m., clinic nurse (CN)-I stated the clinic received a fax the afternoon of October 24, 2022, that indicated the resident had been very sleepy and complained of cough, cold symptoms and the resident's oxygen had been 77% on room air and was using supplemental oxygen. CN-I stated a concern related to oxygen levels should have been a phone call instead of a fax. CN-I stated they called the facility after they received the fax but were told a nurse was not available to assess the patient. CN-I stated due to the symptoms reported, they recommended the patient be seen that day but were told an appointment had already been made for the next day. CN-I stated when the resident came in for her appointment on October 25, 2022, she was not wearing any oxygen and her oxygen level was 83%. CN-I stated they immediately sent the resident to the	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 6 emergency room due to her low oxygen levels. On November 21, 2022, at 11:15 a.m., RN-B stated she assessed the resident in person on Monday morning [October 24, 2022]. The resident had a recorded oxygen saturation level of 77% on room air that morning. RN-B stated the resident's oxygen was running up to 90% while on supplemental oxygen and the resident reported she was feeling better, so it didn't seem urgent that she be seen by a provider. RN-B stated she felt their response to the resident's low oxygen levels was appropriate because RN-F had been notified over the weekend, she had assessed the resident in person, a fax was sent to the resident's primary care provider, and an appointment was made for the resident to be seen. RN-B stated a fax versus a phone call to the primary care provider was appropriate as that was the local clinic's preferred method of communication. RN-B stated they probably should have increased the frequency of checking the resident's oxygen levels. On November 22, 2022, at 8:45 a.m., RN-F stated she worked remotely and takes call for several of the locations operated by the licensee and did not work at the facility. RN-F stated she had a busy weekend with calls so her note on the resident's low oxygen levels that occurred on October 23, 2022, was a late entry completed on October 24, 2022. RN-F stated facility staff called her on Sunday, October 23, 2022, because staff did not want the resident to go out of the building with family since her oxygen levels had not been stable. RN-F stated she was not aware when the resident started on oxygen or if she used oxygen at baseline, but the resident's oxygen was around 82% while on 3 liters of supplemental oxygen. RN-F stated, "when we're on call for all the	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 7 assisted livings, we just have a little snapshot of the resident." RN-F stated she directed staff they had to let the resident leave for the outing and that she was not concerned her oxygen levels were not holding as her other vital signs were normal. RN-F stated since the resident did not have shortness of breath, she didn't feel the resident needed to be seen by a provider because "besides the oxygen being a tich low, everything else was normal." RN-F confirmed she did not give staff any further direction or guidance of increasing checking oxygen saturation levels or when to send to the emergency room. RN-F stated, the "only thing abnormal was her oxygen and it wasn't terribly low and the rest of the vitals were within normal limits." RN-F stated if the resident would have had fever or other abnormal vitals, along with an 85% oxygen saturation level, she would have recommended the resident go in for an evaluation by a physician. RN-F stated anything below 85% is generally concerning but it's a case-by-case basis on whether or not someone needs to be seen. On November 23, 2022, at 8:35 a.m., ULP-E stated they had contacted RN-F about four times from Saturday, October 23, 2022, to Sunday, October 24, 2022. ULP-E stated they noticed the resident's oxygen was low on Saturday morning [October 22, 2022] and used a standing as needed (PRN) order for supplemental oxygen. ULP-E stated usually the resident's oxygen levels come back up and they can discontinue using the PRN oxygen. However, when the resident's levels didn't get above either 84 or 85% while on the supplemental oxygen, they contacted RN-F. ULP-E stated RN-F did not direct staff to increase monitoring of the resident's oxygen levels or give direction on when to send the resident to the hospital. ULP-E stated RN-F advised staff to just	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 8 keep an eye on it. ULP-E stated she was concerned for the resident because she had a slight cold and "you could hear it in her chest. I was concerned about it because her oxygen is low sometimes but when we have her sitting there with oxygen on for three, four hours and it's still at 86%, I was concerned." ULP-E stated the resident's oxygen was still low on Sunday [October 23, 2022] and they called RN-F again when the resident's family wanted to take her out of the facility and the staff did not feel the resident's oxygen levels were stable enough to go out. ULP-E stated RN-F did not direct staff to send the resident to the emergency room and the call was focused on the resident's right to leave the facility. ULP-E stated the resident did not have a portable oxygen tank and went out with family without any supplemental oxygen. ULP-E stated when the resident returned from the outing, her oxygen levels were low and she believed another staff member contacted RN-F for further guidance. ULP-E stated at no point over the weekend did RN-F direct staff to increase monitoring of oxygen levels or give guidance of when to send the resident to the emergency room. ULP-E stated she did increase the frequency of checking of the resident's oxygen levels herself since she was concerned and thought it should be checked more often. On November 23, 2022, at 3:30 p.m., ULP-D stated she had reached out to RN-F twice due to her concerns the resident's oxygen level was not improving despite being on supplemental oxygen. ULP-D stated the resident had been really sleepy and had some cold symptoms Sunday morning [October 23, 2022]. ULP-D stated when she called RN-F the morning of October 23, 2022, to report the low oxygen levels, RN-F directed her to put supplemental oxygen on the resident. ULP-D	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 9 stated she told the nurse the resident was already on oxygen and still had an 82% oxygen level. ULP-D stated she was then directed to continue monitoring the oxygen levels, but no tasks or directions were entered in the resident's electronic medical record to alert staff of when to check it or where to enter updated oxygen saturation levels. ULP-D stated she continued to periodically check the resident's oxygen levels and it remained around 80% on supplemental oxygen. ULP-D stated she called RN-F later that afternoon because family wanted to take the resident out and she was uncomfortable with that because the resident's oxygen saturation had not improved. ULP-D stated RN-F was focused on the resident's rights to leave instead of her current health status, and they were directed they had to let the resident go out. ULP-D stated at no time did RN-F direct her to increase the frequency of checking vital signs or given any direction of when to send to the emergency room. On November 28, 2022, at 9:30 a.m., RN-B stated the wheezing noted in the resident's lungs was concerning but there was RSV going through the facility at that time. RN-B stated they felt they handled the situation appropriately by using supplemental oxygen as they were treating the symptoms, just like they would have done in the hospital. RN-B stated she was not aware additional calls had been placed to RN-F and was only aware of the one call that was documented by RN-F on October 23, 2022. On November 28, 2022, at 1:00 p.m., primary care provider (PCP)-H stated since the facility was aware there were cases of RSV in the facility and the resident was displaying symptoms consistent with RSV, the facility should have sent the resident in for evaluation sooner. PCP-H	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 10 stated since the resident was not on oxygen at baseline, was now requiring supplemental oxygen and still not maintaining oxygen saturation levels above 90%, she would have expected the facility send the resident in to the emergency room for further evaluation when it was noted on Saturday [October 22, 2022]. PCP-H stated the clinic would expect a phone call regarding the low oxygen concern, not a fax, since the issue was related to the overall health status of a resident. PCP-H stated it would have been a red flag to send the resident in immediately if her oxygen saturation levels were still in the 80's on oxygen, especially since the resident is not normally on oxygen. On November 28, 2022, at 1:20 p.m., licensed assisted living director (LALD)-A confirmed a MAARC report had not been filed and they were still investigating the incident to determine if neglect may have occurred. LALD-A stated since she was not at the facility the Saturday and Sunday in question, she was "totally in the dark" on what happened. LALD-A stated since the resident's family took her out of the facility that Sunday and weren't concerned about the resident's oxygen saturation levels, she wasn't concerned. LALD-A stated she would have to talk to home health aides (ULPs) to get more information on what happened over that weekend. LALD-A stated since RN-B had assessed the resident that Monday and she thought it was handled. The licensee's Vulnerable Adults, Keeping our Residents Safe policy, dated August 1, 2021, indicated neglect (failure of caretaker to provide necessary health care or supervision) would be reported immediately to the Assisted Living Director, Direct Supervisor and Company Supervisor(s) & Officer(s). The policy indicated	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 11 immediately is defined as soon as possible but within 24 hours. When in doubt, make a report. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 12 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employees (registered nurse/RN-B). 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 13 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: RN-B was hired on March 28, 2022 to provide direct care to the residents and supervise the staff. On November 28, 2022, training records, including vulnerable adult reporting training, were requested. On November 30, 2022, RN-B sent the surveyor her employee record via email. RN-B's employee record lacked the following required orientation content: -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=J	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.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 14 (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 interview and record review, the licensee failed to ensure the registered nurse (RN-F) appropriately completed assessments as required for one of one residents (R1) with records reviewed. In addition, the licensee failed to ensure the RN (RN-B) completed assessments that accurately reflected the resident's current condition for one of one residents (R1). This practice resulted in a level four violation (a violation that results in 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: Two facility registered nurses (RN-B and RN-F)	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 15 failed to appropriately assess R1's change in condition and respond to reports of oxygen saturation levels below normal ranges. R1 experienced oxygen saturation levels around 80% (normal range is 90%-100%) for three days, October 22, October 23, October 24, 2022. Unlicensed personnel (ULP)-D and ULP-E reported abnormal oxygen saturation levels to RN-F on October 22 and October 23, 2022. RN-B assessed R1 in person on October 24, 2022, with noted abnormal findings. The abnormal oxygen saturation levels were not reported to a physician until mid-afternoon on October 24, 2022, when RN-B sent the provider a faxed update and the resident was not sent in for further care until October 25, 2022. The resident was sent to the emergency room from the clinic appointment due to low oxygen saturation levels. R1's diagnoses included type two diabetes and hypertension (high blood pressure.) R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. The resident's progress notes indicated on October 23, 2022, the resident had a temperature of 99.9 degrees Fahrenheit that morning. The resident's progress notes indicate RN-F was called October 23, 2022, and "staff reported the resident's oxygen level was running between 82-90% despite having oxygen on at 3 liters. Resident was also complaining of a cough and cold." The resident was wanting to go out of the facility with family and the "RN instructed staff to encourage resident to stay at the ALF [assisted living facility], however, she can go out if she	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 16 chooses." The note indicated staff were to tell the resident to come back to the facility if she continued to feel ill. A progress note entered by RN-B on October 24, 2022, indicated she had assessed the resident in person due to a report of the resident not feeling well and experiencing cold like symptoms over the weekend. The progress note indicated the resident was "feeling better but was still having some cold like symptoms including a productive cough ...general fatigue, and occasional shortness of breath when she exerts herself." RN-B's progress note indicated wheezes in R1's lower lung lobes were present. The resident's oxygen was 91% on 3 liters of oxygen and had a temperature of 99.3 degrees Fahrenheit. A covid test was completed, which was negative. R1's record contained a fax that was sent to the resident's primary care provider at the local clinic on October 24, 2022, at 11:26 a.m. The fax asked the provider to "please advise as there is positive cases of RSV in the facility." A copy of the resident's most recent vital signs was included, including the resident having a 77% oxygen saturation on room air. A progress note entered on October 24, 2022, at 3:28 p.m. by RN-B indicated an appointment was made for R1 to be seen in the clinic on October 25, 2022. The resident's hospital records indicated the resident was sent to the emergency room on October 25, 2022, after having low oxygen levels at a clinic visit. The resident's history and physical indicated the resident had a cough over the last two to three weeks and reported having shortness of breath for a couple of weeks. The	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 17 resident was hospitalized for 11 days and diagnosed with acute respiratory failure with hypoxia, RSV (respiratory Syncytial virus) pneumonia, and a pulmonary embolism. The hospital records indicated the resident was not on supplemental oxygen prior to her admission to the hospital. The resident returned to the facility with orders for continuous supplemental oxygen. On November 17, 2022, at 10:15 a.m., clinic nurse (CN)-I stated they received a fax the afternoon of October 24, 2022, that indicated the resident had been very sleepy and complained of cough, cold symptoms and the resident's oxygen had been 77% on room air and was using supplemental oxygen. CN-I stated a concern related to oxygen levels should have been a phone call instead of a fax. CN-I stated they called the facility after they received the fax but were told a nurse was not available to assess the patient. CN-I stated due to the symptoms reported, they recommended the patient be seen that day but were told an appointment had already been made for the next day. CN-I stated when the resident came in for her appointment on October 25, 2022, she was not wearing any oxygen and her oxygen level was 83%. CN-I stated they immediately sent the resident to the emergency room due to her low oxygen levels. On November 21, 2022, at 11:15 a.m., RN-B stated she assessed the resident in person on Monday morning [October 24, 2022]. The resident had a recorded oxygen saturation level of 77% on room air that morning. RN-B stated the resident's oxygen was running up to 90% while on supplemental oxygen and the resident reported she was feeling better, so it didn't seem urgent that she be seen by a provider. RN-B stated she felt their response to the resident's low	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 18 oxygen levels was appropriate because RN-F had been notified over the weekend, she had assessed the resident in person, a fax was sent to the resident's primary care provider, and an appointment was made for the resident to be seen. RN-B stated a fax versus a phone call to the primary care provider was appropriate as that was the local clinic's preferred method of communication. RN-B stated they probably should have increased the frequency of checking the resident's oxygen levels. On November 22, 2022, at 8:45 a.m., RN-F stated she worked remotely and takes call for several of the locations operated by the licensee and did not work at the facility. RN-F stated she had a busy weekend with calls so her note on the resident's low oxygen levels that occurred on October 23, 2022, was a late entry completed on October 24, 2022. RN-F stated facility staff called her on Sunday, October 23, 2022, because staff did not want the resident to go out of the building with family since her oxygen levels had not been stable. RN-F stated she was not aware when the resident started on oxygen or if she used oxygen at baseline, but the resident's oxygen was around 82% while on 3 liters of supplemental oxygen. RN-F stated, "when we're on call for all the assisted livings, we just have a little snapshot of the resident." RN-F stated she directed staff they had to let the resident leave for the outing and that she was not concerned her oxygen levels were not holding as her other vital signs were normal. RN-F stated since the resident did not have shortness of breath, she didn't feel the resident needed to be seen by a provider because "besides the oxygen being a tich low, everything else was normal." RN-F confirmed she did not give staff any further direction or guidance of increasing checking oxygen saturation levels or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 19 when to send to the emergency room. RN-F stated, the "only thing abnormal was her oxygen and it wasn't terribly low and the rest of the vitals were within normal limits." RN-F stated if the resident would have had fever or other abnormal vitals, along with an 85% oxygen saturation level, she would have recommended the resident go in for an evaluation by a physician. RN-F stated anything below 85% is generally concerning but it's a case-by-case basis on whether or not someone needs to be seen. On November 23, 2022, at 8:35 a.m., ULP-E stated they had contacted RN-F about four times from Saturday, October 23, 2022, to Sunday, October 24, 2022. ULP-E stated they noticed the resident's oxygen was low on Saturday morning [October 22, 2022] and used a standing as needed (PRN) order for supplemental oxygen. ULP-E stated usually the resident's oxygen levels come back up and they can discontinue using the PRN oxygen. However, when the resident's levels didn't get above either 84 or 85% while on the supplemental oxygen, they contacted RN-F. ULP-E stated RN-F did not direct staff to increase monitoring of the resident's oxygen levels or give direction on when to send the resident to the hospital. ULP-E stated RN-F advised staff to just keep an eye on it. ULP-E stated she was concerned for the resident because she had a slight cold and "you could hear it in her chest. I was concerned about it because her oxygen is low sometimes but when we have her sitting there with oxygen on for three, four hours and it's still at 86%, I was concerned." ULP-E stated the resident's oxygen was still low on Sunday [October 23, 2022] and they called RN-F again when the resident's family wanted to take her out of the facility and the staff did not feel the resident's oxygen levels were stable enough to go	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 20 out. ULP-E stated RN-F did not direct staff to send the resident to the emergency room and the call was focused on the resident's right to leave the facility. ULP-E stated the resident did not have a portable oxygen tank and went out with family without any supplemental oxygen. ULP-E stated when the resident returned from the outing, her oxygen levels were low and she believed another staff member contacted RN-F for further guidance. ULP-E stated at no point over the weekend did RN-F direct staff to increase monitoring of oxygen levels or give guidance of when to send the resident to the emergency room. ULP-E stated she did increase the frequency of checking of the resident's oxygen levels since she was concerned and thought it should be checked more often. On November 23, 2022, at 3:30 p.m., ULP-D stated she had reached out to RN-F twice due to her concerns the resident's oxygen level was not improving despite being on supplemental oxygen. ULP-D stated the resident had been really sleepy and had some cold symptoms Sunday morning [October 23, 2022]. ULP-D stated when she called RN-F the morning of October 23, 2022, to report the low oxygen levels, RN-F directed her to put supplemental oxygen on the resident. ULP-D stated she told the nurse the resident was already on oxygen and still had an 82% oxygen level. ULP-D stated she was then directed to continue monitoring the oxygen levels, but no tasks or directions were entered in the resident's electronic medical record to alert staff of when to check it or where to enter updated oxygen saturation levels. ULP-D stated she continued to periodically check the resident's oxygen levels and it remained around 80% on supplemental oxygen. ULP-D stated she called RN-F later that afternoon because family wanted to take the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 21 resident out and she was uncomfortable with that because the resident's oxygen saturation had not improved. ULP-D stated RN-F was focused on the resident's rights to leave instead of her current health status, and they were directed they had to let the resident go out. ULP-D stated at no time did RN-F direct her to increase the frequency of checking vital signs or given any direction of when to send to the emergency room. On November 28, 2022, at 9:30 a.m., RN-B stated the wheezing noted in the resident's lungs was concerning but there was RSV going through the facility at that time. RN-B stated they felt they handled the situation appropriately by using supplemental oxygen as they were treating the symptoms, just like they would have done in the hospital. RN-B stated she was not aware additional calls had been placed to RN-F and was only aware of the one call that was documented by RN-F on October 23, 2022. On November 28, 2022, at 1:00 p.m., primary care provider (PCP)-H stated since the facility was aware there were cases of RSV in the facility and the resident was displaying symptoms consistent with RSV, the facility should have sent the resident in for evaluation sooner. PCP-H stated since the resident was not on oxygen at baseline, was now requiring supplemental oxygen and still not maintaining oxygen saturation levels above 90%, she would have expected the facility send the resident in to the emergency room for further evaluation when it was noted on Saturday [October 22, 2022]. PCP-H stated the clinic would expect a phone call regarding the low oxygen concern, not a fax, since the issue was related to the overall health status of a resident. PCP-H stated it would have been a red flag to send the resident in immediately if her oxygen saturation	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 22 levels were still in the 80's on oxygen, especially since the resident is not normally on oxygen. The licensee's Assessment, Monitoring, & Reassessment policy, dated August 1, 2021, indicated the RN would complete an assessment in person or via telecommunications if necessitated by geographical distance or urgent/unexpected circumstances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=D	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: (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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 23 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 one of one residents (R1) with records reviewed. 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 type two diabetes and hypertension (high blood pressure). R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. R1's service plan lacked the following required content for the treatment services the resident was receiving: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 24 assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; R1's prescriber orders dated February 12, 2021, included a standing order for oxygen at 1 to 4 liters per minute via nasal cannula PRN (as needed) for emergency use. R1's prescriber orders dated November 4, 2022, included orders for continuous oxygen at 1 liter per minute via nasal cannula at rest and 3 liters per minute via nasal cannula with activity. Progress notes indicate R1 began using as needed/PRN oxygen around October 23, 2022 through her hospitalization on October 25, 2022. R1 returned to the facility on November 4, 2022, with new orders for continuous oxygen. R1's October 2022 medication administration record (MAR) and service recap summary (documentation of services provided to the resident) lacked documentation of R1 using PRN oxygen. R1's November 2022 MAR and service recap summary lacked documentation of the resident's new orders or use of continuous oxygen. On November 21, 2022, at 8:35 a.m., the surveyor observed R1 sitting in her bedroom with continuous oxygen on. Unlicensed personnel (ULP)-J observed and verified the oxygen concentrator to be set at 2 liters per minute. On November 21, 2022, at 8:50 a.m., ULP-J switched R1's oxygen over to the oxygen tank so she could be brought down to the scale to obtain her weight. The surveyor observed ULP-J set the	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 25 oxygen tank to 2 liters per minute, ULP-J confirmed it was set to 2 liters. On November 28, 2022 at 9:25 a.m., registered nurse (RN)-B confirmed oxygen management services were not included on the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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; (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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 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 ensure the registered nurse developed an individualized treatment management plan with all required content for one of one residents (R1) who had ordered treatments. 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 type two diabetes and hypertension (high blood pressure.) R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. R1's record lacked a treatment management plan for oxygen.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 R1's prescriber orders dated February 12, 2021, included a standing order for oxygen at 1 to 4 liters per minute via nasal cannula PRN (as needed) for emergency use. R1's prescriber orders dated November 4, 2022, included orders for continuous oxygen at 1 liter per minute via nasal cannula at rest and 3 liters per minute via nasal cannula with activity. On November 21, 2022, at 8:35 a.m., the surveyor observed R1 sitting in her bedroom with continuous oxygen on. Unlicensed personnel (ULP)-J observed and verified the oxygen concentrator to be set at 2 liters per minute. On November 21, 2022, at 8:50 a.m., ULP-J switched R1's oxygen over to the oxygen tank so she could be brought down to the scale to obtain her weight. The surveyor observed ULP-J set the oxygen tank to 2 liters per minute, ULP-J confirmed it was set to 2 liters. R1's record lacked a treatment management plan for use of oxygen that included: -statement of the type of services that will be provided; -documentation of specific resident instructions relating to treatment or therapy; -identification of the treatment or therapy tasks that may be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment or therapy received. On November 28, 2022 at 9:25 a.m., registered	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 28 nurse (RN)-B confirmed R1 did not have a treatment plan for the use of oxygen. The licensee's Medication & Treatment Management Plan(s) policy, dated August 1, 2021, indicated medication and treatment management services provided by ULP to home care residents would be performed consistent with Minnesota's Comprehensive Home Care Rules. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 29 about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific written instructions for each resident were documented in one of one resident's record (R1) who received oxygen management. 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 type two diabetes and hypertension (high blood pressure). R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. R1's record lacked a treatment management plan for oxygen. R1's prescriber orders dated February 12, 2021, included a standing order for oxygen at 1 to 4 liters per minute via nasal cannula PRN (as needed) for emergency use. R1's prescriber orders dated November 4, 2022,	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 30 included orders for continuous oxygen at 1 liter per minute via nasal cannula at rest and 3 liters per minute via nasal cannula with activity. Progress notes indicated R1 began using as needed/PRN oxygen around October 23, 2022 through her hospitalization on October 25, 2022. R1 returned to the facility on November 4, 2022, with new orders for continuous oxygen. R1's October 2022 medication administration record (MAR) and service recap summary (documentation of services provided to the resident) lacked documentation of R1 using PRN oxygen. R1's November 2022 MAR and service recap summary lacked documentation of the resident's new orders or use of continuous oxygen. R1's November 2022 service recap summary indicated the resident was on 2 liters of oxygen on November 6, 12, 16, 2022 when staff recorded the resident's oxygen saturation levels. On November 21, 2022, at 8:35 a.m., the surveyor observed R1 sitting in her bedroom with continuous oxygen on. Unlicensed personnel (ULP)-J observed and verified the oxygen concentrator to be set at 2 liters per minute. On November 21, 2022, at 8:50 a.m., ULP-J switched R1's oxygen over to the oxygen tank so she could be brought down to the scale to obtain her weight. The surveyor observed ULP-J set the oxygen tank to 2 liters per minute, ULP-J confirmed it was set to 2 liters. On November 28, 2022 at 9:25 a.m., registered nurse (RN)-B confirmed oxygen orders had not	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 31 been added to the resident's medical record. The licensee's Medication & Treatment Management Plan(s) policy, dated August 1, 2021, indicated medication and treatment management services provided by ULP to home care residents would be performed consistent with Minnesota's Comprehensive Home Care Rules. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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 review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of one residents (R1) with oxygen managed by the provider.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 32 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: R1's diagnoses included type two diabetes and hypertension (high blood pressure.) R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. R1's record lacked a treatment management plan for oxygen. R1's prescriber orders dated February 12, 2021, included a standing order for oxygen at 1 to 4 liters per minute via nasal cannula PRN (as needed) for emergency use. R1's prescriber orders dated November 4, 2022, included orders for continuous oxygen at 1 liter per minute via nasal cannula at rest and 3 liters per minute via nasal cannula with activity. Progress notes indicate R1 began using as needed/PRN oxygen around October 23, 2022 through her hospitalization on October 25, 2022. R1 returned to the facility on November 4, 2022, with new orders for continuous oxygen.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 33 R1's October 2022 medication administration record (MAR) and service recap summary (documentation of services provided to the resident) lacked documentation of R1 using PRN oxygen. R1's November 2022 MAR and service recap summary lacked documentation of the resident's new orders or use of continuous oxygen. R1's November 2022 service recap summary indicated the resident was on 2 liters of oxygen on November 6, 12, 16, 2022 when staff recorded the resident's oxygen saturation levels. On November 21, 2022, at 8:35 a.m., the surveyor observed R1 sitting in her bedroom with continuous oxygen on. Unlicensed personnel (ULP)-J observed and verified the oxygen concentrator to be set at 2 liters per minute. On November 21, 2022, at 8:50 a.m., ULP-J switched R1's oxygen over to the oxygen tank so she could be brought down to the scale to obtain her weight. The surveyor observed ULP-J set the oxygen tank to 2 liters per minute, ULP-J confirmed it was set to 2 liters. On November 28, 2022 at 9:25 a.m., registered nurse (RN)-B confirmed oxygen orders had not been added to the resident's medical record. The licensee's Medication & Treatment Management Plan(s) policy, dated August 1, 2021, indicated medication and treatment management services provided by ULP to home care residents would be performed consistent with Minnesota's Comprehensive Home Care Rules.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02320 SS=J	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident received health care services from people who were properly trained and competent when two registered nurses (RN)-B and RN-F) failed to assess and monitor a resident's change in condition for 1 of 1 (R1) residents reviewed. This practice resulted in a level four violation (a violation that results in 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: Two facility registered nurses (RN-B and RN-F) failed to appropriately assess R1's change in condition and respond to reports of oxygen	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 35 saturation levels below normal ranges. R1 experienced oxygen saturation levels around 80% (normal range is 90%-100%) for three days, October 22, October 23, October 24, 2022. Unlicensed personnel (ULP)-D and ULP-E reported abnormal oxygen saturation levels to RN-F on October 22 and October 23, 2022. RN-B assessed R1 in person on October 24, 2022, with noted abnormal findings. The abnormal oxygen saturation levels were not reported to a physician until mid-afternoon on October 24, 2022, when RN-B faxed the update to the clinic and the resident was not sent in for further care until October 25, 2022. The resident was sent to the emergency room from the next day's clinic appointment due to low oxygen saturation levels. R1's diagnoses included type two diabetes and hypertension (high blood pressure.) R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. The resident's progress notes indicated on October 23, 2022, the resident had a temperature of 99.9 degrees Fahrenheit that morning. The resident's progress notes indicate RN-F was called October 23, 2022, and "staff reported the resident's oxygen level was running between 82-90% despite having oxygen on at 3 liters. Resident was also complaining of a cough and cold." The resident was wanting to go out of the facility with family and the "RN instructed staff to encourage resident to stay at the ALF [assisted living facility], however, she can go out if she chooses." The note indicated staff were to tell the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 36 resident to come back to the facility if she continued to feel ill. A progress note entered by RN-B on October 24, 2022, indicated she had assessed the resident in person due to a report of the resident not feeling well and experiencing cold like symptoms over the weekend. The progress note indicated the resident was "feeling better but was still having some cold like symptoms including a productive cough ...general fatigue, and occasional shortness of breath when she exerts herself." RN-B's progress note indicated wheezes in R1's lower lung lobes were present. The resident's oxygen was 91% on 3 liters of oxygen and had a temperature of 99.3 degrees Fahrenheit. A covid test was completed, which was negative. R1's record contained a fax that was sent to the resident's primary care provider at the local clinic on October 24, 2022, at 11:26 a.m. The fax asked the provider to "please advise as there is positive cases of RSV in the facility." A copy of the resident's most recent vital signs was included, including the resident having a 77% oxygen saturation on room air. A progress note entered on October 24, 2022, at 3:28 p.m. by RN-B indicated an appointment was made for R1 to be seen in the clinic on October 25, 2022. The resident's hospital records indicated the resident was sent to the emergency room on October 25, 2022, after having low oxygen levels at a clinic visit. The resident's history and physical indicated the resident had a cough over the last two to three weeks and reported having shortness of breath for a couple of weeks. The resident was hospitalized for 11 days and	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 37 diagnosed with acute respiratory failure with hypoxia, RSV (respiratory Syncytial virus) pneumonia, and a pulmonary embolism. The hospital records indicated the resident was not on supplemental oxygen prior to her admission to the hospital. The resident returned to the facility with orders for continuous supplemental oxygen. On November 17, 2022, at 10:15 a.m., clinic nurse (CN)-I stated they received a fax the afternoon of October 24, 2022, that indicated the resident had been very sleepy and complained of cough, cold symptoms and the resident's oxygen had been 77% on room air and was using supplemental oxygen. CN-I stated a concern related to oxygen levels should have been a phone call instead of a fax. CN-I stated they called the facility after they received the fax but were told a nurse was not available to assess the patient. CN-I stated due to the symptoms reported, they recommended the patient be seen that day but were told an appointment had already been made for the next day. CN-I stated when the resident came in for her appointment on October 25, 2022, she was not wearing any oxygen and her oxygen level was 83%. CN-I stated they immediately sent the resident to the emergency room due to her low oxygen levels. On November 21, 2022, at 11:15 a.m., RN-B stated she assessed the resident in person on Monday morning [October 24, 2022]. The resident had a recorded oxygen saturation level of 77% on room air that morning. RN-B stated the resident's oxygen was running up to 90% while on supplemental oxygen and the resident reported she was feeling better, so it didn't seem urgent that she be seen by a provider. RN-B stated she felt their response to the resident's low oxygen levels was appropriate because RN-F had	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 38 been notified over the weekend, she had assessed the resident in person, a fax was sent to the resident's primary care provider, and an appointment was made for the resident to be seen. RN-B stated a fax versus a phone call to the primary care provider was appropriate as that was the local clinic's preferred method of communication. RN-B stated they probably should have increased the frequency of checking the resident's oxygen levels. On November 22, 2022, at 8:45 a.m., RN-F stated she works remotely and takes call for several of the locations operated by the licensee and does not work at the facility. RN-F stated she had a busy weekend with calls so her note on the resident's low oxygen levels that occurred on October 23, 2022, was a late entry completed on October 24, 2022. RN-F stated facility staff called her on Sunday, October 23, 2022, because staff did not want the resident to go out of the building with family since her oxygen levels had not been stable. RN-F stated she was not aware when the resident was started on oxygen or if she used oxygen at baseline, but the resident's oxygen was around 82% while on 3 liters of supplemental oxygen. RN-F stated, "when we're on call for all the assisted livings, we just have a little snapshot of the resident." RN-F stated she directed staff they had to let the resident leave for the outing and that she was not concerned her oxygen levels were not holding as her other vital signs were normal. RN-F stated since the resident did not have shortness of breath, she didn't feel the resident needed to be seen by a provider because "besides the oxygen being a tich low, everything else was normal." RN-F confirmed she did not give staff any further direction or guidance of increasing checking oxygen saturation levels or when to send to the emergency room. RN-F	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 39 stated, the "only thing abnormal was her oxygen and it wasn't terribly low and the rest of the vitals were within normal limits." RN-F stated if the resident would have had fever or other abnormal vitals, along with an 85% oxygen saturation level, she would have recommended the resident go in for an evaluation by a physician. RN-F stated anything below 85% is generally concerning but it's a case-by-case basis on whether or not someone needs to be seen. On November 23, 2022, at 8:35 a.m., ULP-E stated they had contacted RN-F about four times from Saturday, October 23, 2022, to Sunday, October 24, 2022. ULP-E stated they noticed the resident's oxygen was low on Saturday morning [October 22, 2022] and used a standing as needed (PRN) order for supplemental oxygen. ULP-E stated usually the resident's oxygen levels come back up and they can discontinue using the PRN oxygen. However, when the resident's levels didn't get above either 84 or 85% while on the supplemental oxygen, they contacted RN-F. ULP-E stated RN-F did not direct staff to increase monitoring of the resident's oxygen levels or give direction on when to send the resident to the hospital. ULP-E stated RN-F advised staff to just keep an eye on it. ULP-E stated she was concerned for the resident because she had a slight cold and "you could hear it in her chest. I was concerned about it because her oxygen is low sometimes but when we have her sitting there with oxygen on for three, four hours and it's still at 86%, I was concerned." ULP-E stated the resident's oxygen was still low on Sunday [October 23, 2022] and they called RN-F again when the resident's family wanted to take her out of the facility and the staff did not feel the resident's oxygen levels were stable enough to go out. ULP-E stated RN-F did not direct staff to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 40 send the resident to the emergency room and the call was focused on the resident's right to leave the facility. ULP-E stated the resident did not have a portable oxygen tank and went out with family without any supplemental oxygen. ULP-E stated when the resident returned from the outing, her oxygen levels were low and she believed another staff member contacted RN-F for further guidance. ULP-E stated at no point over the weekend did RN-F direct staff to increase monitoring of oxygen levels or give guidance of when to send the resident to the emergency room. ULP-E stated she did increase the frequency of checking of the resident's oxygen levels since she was concerned and thought it should be checked more often. On November 23, 2022, at 3:30 p.m., ULP-D stated she had reached out to RN-F twice due to her concerns the resident's oxygen level was not improving despite being on supplemental oxygen. ULP-D stated the resident had been really sleepy and had some cold symptoms Sunday morning [October 23, 2022]. ULP-D stated when she called RN-F the morning of October 23, 2022, to report the low oxygen levels, RN-F directed her to put supplemental oxygen on the resident. ULP-D stated she told the nurse the resident was already on oxygen and still had an 82% oxygen level. ULP-D stated she was then directed to continue monitoring the oxygen levels, but no tasks or directions were entered in the resident's electronic medical record to alert staff of when to check it or where to enter updated oxygen saturation levels. ULP-D stated she continued to periodically check the resident's oxygen levels and it remained around 80% on supplemental oxygen. ULP-D stated she called RN-F later that afternoon because family wanted to take the resident out and she was uncomfortable with that	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 41 because the resident's oxygen saturation had not improved. ULP-D stated RN-F was focused on the resident's rights to leave instead of her current health status, and they were directed they had to let the resident go out. ULP-D stated at no time did RN-F direct her to increase the frequency of checking vital signs or given any direction of when to send to the emergency room. On November 28, 2022, at 9:30 a.m., RN-B stated the wheezing noted in the resident's lungs was concerning but there was RSV going through the facility at that time. RN-B stated they felt they handled the situation appropriately by using supplemental oxygen as they were treating the symptoms, just like they would have done in the hospital. RN-B stated she was not aware additional calls had been placed to RN-F and was only aware of the one call that was documented by RN-F on October 23, 2022. On November 28, 2022, at 1:00 p.m., primary care provider (PCP)-H stated since the facility was aware there were cases of RSV in the facility and the resident was displaying symptoms consistent with RSV, the facility should have sent the resident in for evaluation sooner. PCP-H stated since the resident was not on oxygen at baseline and was now requiring supplemental oxygen and still not maintaining oxygen saturation levels above 90%, she would have expected the facility send the resident in to the emergency room for further evaluation when it was noted on Saturday [October 22, 2022]. PCP-H stated the clinic would expect a phone call regarding the low oxygen concern, not a fax, since the issue was related to the overall health status of a resident. PCP-H stated it would have been a red flag to send the resident in immediately if her oxygen saturation levels were still in the 80's on oxygen,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 42 especially since the resident is not normally on oxygen. The licensee's On Call Process policy, dated August 1, 2022, indicated the on-call RN would enter detailed documentation in the resident's chart following the resolution of the call. The policy further indicated if there was any doubt regarding the seriousness of the resident's condition, including after contacting the on-call RN, staff were to call 911 immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 residents, (R1), reviewed was free from maltreatment. The resident was neglected. Findings include: On November 28, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02360	Continued From page 43 preponderance of evidence that maltreatment occurred.	02360		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 44 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) with a change in condition. 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 failed to immediately report to the provider a change in condition for R1, resulting in a delay of care. Two facility registered nurses (RN-B and RN-F) failed to appropriately assess R1's change in condition and respond to reports	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 45 of oxygen saturation levels below normal ranges. R1 experienced oxygen saturation levels around 80% (normal range is 90%-100%) for three days, October 22, October 23, October 24, 2022. Unlicensed personnel (ULP)-D and ULP-E reported abnormal oxygen saturation levels to RN-F on October 22 and October 23, 2022. RN-B assessed R1 in person on October 24, 2022, with noted abnormal findings. The abnormal oxygen saturation levels were not immediately reported to a physician until mid-afternoon on October 24, 2022, and the resident was not sent in for further care until October 25, 2022. The resident was sent to the emergency room from the clinic appointment due to low oxygen saturation levels. The licensee failed to investigate the incident or report it to MAARC, even after a complaint investigation was initiated by the Minnesota Department of Health. R1's diagnoses included type two diabetes and hypertension (high blood pressure). R1's service plan dated August 1, 2022, indicated the resident received assistance with mobility, bathing, and medication administration. The service plan did not contain any oxygen management services. The resident's progress notes indicated on October 23, 2022, the resident had a temperature of 99.9 degrees Fahrenheit that morning. The resident's progress notes indicate RN-F was called October 23, 2022, and "staff reported the resident's oxygen level was running between 82-90% despite having oxygen on at 3 liters. Resident was also complaining of a cough and cold." The resident was wanting to go out of the facility with family and the "RN instructed staff to encourage resident to stay at the ALF [assisted	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 46 living facility], however, she can go out if she chooses." The note indicated staff were to tell the resident to come back to the facility if she continued to feel ill. A progress note entered by RN-B on October 24, 2022, indicated she had assessed the resident in person due to a report of the resident not feeling well and experiencing cold like symptoms over the weekend. The progress note indicated the resident was "feeling better but was still having some cold like symptoms including a productive cough ...general fatigue, and occasional shortness of breath when she exerts herself." RN-B's progress note indicated wheezes in R1's lower lung lobes were present. The resident's oxygen was 91% on 3 liters of oxygen and had a temperature of 99.3 degrees Fahrenheit. A covid test was completed, which was negative. R1's record contained a fax that was sent to the resident's primary care provider at the local clinic on October 24, 2022, at 11:26 a.m. The fax asked the provider to "please advise as there is positive cases of RSV in the facility." A copy of the resident's most recent vital signs was included, including the resident having a 77% oxygen saturation on room air. A progress note entered on October 24, 2022, at 3:28 p.m. by RN-B indicated an appointment was made for R1 to be seen in the clinic on October 25, 2022. The resident's hospital records indicated the resident was sent to the emergency room on October 25, 2022, after having low oxygen levels at a clinic visit. The resident's history and physical indicated the resident had a cough over the last two to three weeks and reported having	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 47 shortness of breath for a couple of weeks. The resident was hospitalized for 11 days and diagnosed with acute respiratory failure with hypoxia, RSV (respiratory Syncytial virus) pneumonia, and a pulmonary embolism. The hospital records indicated the resident was not on supplemental oxygen prior to her admission to the hospital. On November 17, 2022, at 10:15 a.m., clinic nurse (CN)-I stated they received a fax the afternoon of October 24, 2022, that indicated the resident had been very sleepy and complained of cough, cold symptoms and the resident's oxygen had been 77% on room air and was using supplemental oxygen. CN-I stated a concern related to oxygen levels should have been a phone call instead of a fax. CN-I stated they called the facility after they received the fax but were told a nurse was not available to assess the patient. CN-I stated due to the symptoms reported, they recommended the patient be seen that day but were told an appointment had already been made for the next day. CN-I stated when the resident came in for her appointment on October 25, 2022, she was not wearing any oxygen and her oxygen level was 83%. CN-I stated they immediately sent the resident to the emergency room due to her low oxygen levels. On November 21, 2022, at 11:15 a.m., RN-B stated she assessed the resident in person on Monday morning [October 24, 2022]. The resident had a recorded oxygen saturation level of 77% on room air that morning. RN-B stated the resident's oxygen was running up to 90% while on supplemental oxygen and the resident reported she was feeling better, so it didn't seem urgent that she be seen by a provider. RN-B stated she felt their response to the resident's low	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 48 oxygen levels was appropriate because RN-F had been notified over the weekend, she had assessed the resident in person, a fax was sent to the resident's primary care provider, and an appointment was made for the resident to be seen. RN-B stated a fax versus a phone call to the primary care provider was appropriate as that was the local clinic's preferred method of communication. RN-B stated they probably should have increased the frequency of checking the resident's oxygen levels. On November 22, 2022, at 8:45 a.m., RN-F stated she works remotely and takes call for several of the locations operated by the licensee and does not work at the facility. RN-F stated she had a busy weekend with calls so her note on the resident's low oxygen levels that occurred on October 23, 2022, was a late entry completed on October 24, 2022. RN-F stated facility staff called her on Sunday, October 23, 2022, because staff did not want the resident to go out of the building with family since her oxygen levels had not been stable. RN-F stated she was not aware when the resident was started on oxygen or if she used oxygen at baseline, but the resident's oxygen was around 82% while on 3 liters of supplemental oxygen. RN-F stated, "when we're on call for all the assisted livings, we just have a little snapshot of the resident." RN-F stated she directed staff they had to let the resident leave for the outing and that she was not concerned her oxygen levels were not holding as her other vital signs were normal. RN-F stated since the resident did not have shortness of breath, she didn't feel the resident needed to be seen by a provider because "besides the oxygen being a tich low, everything else was normal." RN-F confirmed she did not give staff any further direction or guidance of increasing checking oxygen saturation levels or	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 49 when to send to the emergency room. RN-F stated, the "only thing abnormal was her oxygen and it wasn't terribly low and the rest of the vitals were within normal limits." RN-F stated if the resident would have had fever or other abnormal vitals, along with an 85% oxygen saturation level, she would have recommended the resident go in for an evaluation by a physician. RN-F stated anything below 85% is generally concerning but it's a case-by-case basis on whether or not someone needs to be seen. On November 23, 2022, at 8:35 a.m., ULP-E stated they had contacted RN-F about four times from Saturday, October 23, 2022, to Sunday, October 24, 2022. ULP-E stated they noticed the resident's oxygen was low on Saturday morning [October 22, 2022] and used a standing as needed (PRN) order for supplemental oxygen. ULP-E stated usually the resident's oxygen levels come back up and they can discontinue using the PRN oxygen. However, when the resident's levels didn't get above either 84 or 85% while on the supplemental oxygen, they contacted RN-F. ULP-E stated RN-F did not direct staff to increase monitoring of the resident's oxygen levels or give direction on when to send the resident to the hospital. ULP-E stated RN-F advised staff to just keep an eye on it. ULP-E stated she was concerned for the resident because she had a slight cold and "you could hear it in her chest. I was concerned about it because her oxygen is low sometimes but when we have her sitting there with oxygen on for three, four hours and it's still at 86%, I was concerned." ULP-E stated the resident's oxygen was still low on Sunday [October 23, 2022] and they called RN-F again when the resident's family wanted to take her out of the facility and the staff did not feel the resident's oxygen levels were stable enough to go	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 50 out. ULP-E stated RN-F did not direct staff to send the resident to the emergency room and the call was focused on the resident's right to leave the facility. ULP-E stated the resident did not have a portable oxygen tank and went out with family without any supplemental oxygen. ULP-E stated when the resident returned from the outing, her oxygen levels were low and she believed another staff member contacted RN-F for further guidance. ULP-E stated at no point over the weekend did RN-F direct staff to increase monitoring of oxygen levels or give guidance of when to send the resident to the emergency room. ULP-E stated she did increase the frequency of checking of the resident's oxygen levels since she was concerned and thought it should be checked more often. On November 23, 2022, at 3:30 p.m., ULP-D stated she had reached out to RN-F twice due to her concerns the resident's oxygen level was not improving despite being on supplemental oxygen. ULP-D stated the resident had been really sleepy and had some cold symptoms Sunday morning [October 23, 2022]. ULP-D stated when she called RN-F the morning of October 23, 2022, to report the low oxygen levels, RN-F directed her to put supplemental oxygen on the resident. ULP-D stated she told the nurse the resident was already on oxygen and still had an 82% oxygen level. ULP-D stated she was then directed to continue monitoring the oxygen levels, but no tasks or directions were entered in the resident's electronic medical record to alert staff of when to check it or where to enter updated oxygen saturation levels. ULP-D stated she continued to periodically check the resident's oxygen levels and it remained around 80% on supplemental oxygen. ULP-D stated she called RN-F later that afternoon because family wanted to take the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 51 resident out and she was uncomfortable with that because the resident's oxygen saturation had not improved. ULP-D stated RN-F was focused on the resident's rights to leave instead of her current health status, and they were directed they had to let the resident go out. ULP-D stated at no time did RN-F direct her to increase the frequency of checking vital signs or given any direction of when to send to the emergency room. On November 28, 2022, at 9:30 a.m., RN-B stated the wheezing noted in the resident's lungs was concerning but there was RSV going through the facility at that time. RN-B stated they felt they handled the situation appropriately by using supplemental oxygen as they were treating the symptoms, just like they would have done in the hospital. RN-B stated she was not aware additional calls had been placed to RN-F and was only aware of the one call that was documented by RN-F on October 23, 2022. On November 28, 2022, at 1:00 p.m., primary care provider (PCP)-H stated since the facility was aware there were cases of RSV in the facility and the resident was displaying symptoms consistent with RSV, the facility should have sent the resident in for evaluation sooner. PCP-H stated since the resident was not on oxygen at baseline, was now requiring supplemental oxygen and still not maintaining oxygen saturation levels above 90%, she would have expected the facility send the resident in to the emergency room for further evaluation when it was noted on Saturday [October 22, 2022]. PCP-H stated the clinic would expect a phone call regarding the low oxygen concern, not a fax, since the issue was related to the overall health status of a resident. PCP-H stated it would have been a red flag to send the resident in immediately if her oxygen saturation	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30455	A. BUILDING: _____ B. WING _____	C 11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 52 levels were still in the 80's on oxygen, especially since the resident is not normally on oxygen. On November 28, 2022, at 1:20 p.m., licensed assisted living director (LALD)-A confirmed a MAARC report had not been filed and they were still investigating the incident to determine if neglect may have occurred. LALD-A stated since she was not at the facility the Saturday and Sunday in question, she was "totally in the dark" on what happened. LALD-A stated since the resident's family took her out of the facility that Sunday and weren't concerned about the resident's oxygen saturation levels, she wasn't concerned. LALD-A stated she would have to talk to home health aides (ULPs) to get more information on what happened over that weekend. LALD-A stated since RN-B had assessed the resident that Monday and she thought it was handled. The licensee's Vulnerable Adults, Keeping our Residents Safe policy, dated August 1, 2021, indicated neglect (failure of caretaker to provide necessary health care or supervision) would be reported immediately to the Assisted Living Director, Direct Supervisor and Company Supervisor(s) & Officer(s). The policy indicated immediately is defined as soon as possible but within 24 hours. When in doubt, make a report. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		