Electronically Delivered

August 8, 2024

Licensee
The Gardens at Foley Assisted Living LLC
120 Norman Avenue South
Foley, MN 56329

RE: Project Number(s) SL34338015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

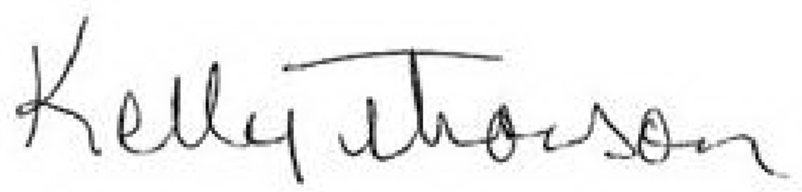
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34338	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT FOLEY AL LLC	120 NORMAN AVENUE SOUTH FOLEY, MN 56329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34338015 On July 15, 2024, through July 18, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 37 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 15, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to	0 570		

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0 570	Continued From page 2 any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On July 15, 2024, at 11:50 a.m., during a facility tour, the surveyor noted the license was not posted at the facility entrance as required and was posted behind a locked office door. On July 15, 2024, at 1:14 p.m., clinical nurse supervisor (CNS)-B stated the license would be moved from the office to the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 3 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 780		

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0 780	Continued From page 4 or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2024, at 1:20 p.m., survey staff toured the facility with director of maintenance (DM)-E. During the tour, survey staff observed the following: 1. Smoke alarms were not installed in the bedrooms for resident dwelling units 103, 105, 109, 201, 203, 207, and 210. During the facility tour interview, DM-E verified smoke alarms were not installed in the bedrooms of these resident units. 2. A smoke alarm was not installed in the bedroom for resident dwelling unit 111. The smoke alarm bracket on the ceiling was empty. During the facility tour interview, DM-E stated they did not know this smoke alarm was missing and stated the alarm would be reinstalled. The licensee failed to provide smoke alarms in each bedroom. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2024, at 1:20 p.m., survey staff toured the facility with director of maintenance (DM)-E. During the tour, survey staff observed the following: 1. The door closer had been removed from the labeled 1-hour fire door leading from the corridor into resident dwelling unit 201. Door closers must be maintained to protect the opening in which they were installed and to protect adjacent spaces. During the facility tour interview, DM-E verified the door closer was missing. 2. The floor plans labeled a storage room on the second floor. A nurse office was located in this space and not identified on the floor plans. The door for the nurse office was a labeled 1-hour fire door with a door closer. The fire door was propped open during the facility tour. A door was not installed between the nurse office and the corridor. Accurate emergency floor plans are	0 800		

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0 800	Continued From page 6 required as part of the evacuation plan for the facility. Propping fire doors in the open position prohibits the required operation and closing feature of the door. During an interview on July 17, 2024, at 3:40 p.m., DM-E verified the nurse office was not labeled on the floor plans and the fire door had been propped open during the tour. 3. One exit door did not positively latch upon closing. During the facility tour interview, DM-E verified this exterior door was not closing properly. 4. In the bedroom of resident dwelling unit 213, one electrical wall outlet cover was installed in a manner that did not encase the outlet. When properly installed, electrical outlet covers are designed to protect against accidental contact with live electrical components. During the facility tour interview, DM-E verified the outlet cover was improperly installed and stated this would be corrected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 7 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, make the plan readily available, and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 8 The findings include: On July 17, 2024, director of maintenance (DM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN During an interview on July 17, 2024, at 3:40 p.m., DM-E explained the FSEP was kept in the emergency preparedness binder that was stored in the nurse office on the second floor. DM-E explained the emergency floor plans were posted but did not know if a copy of the facility FSEP was located elsewhere in the facility. Record review of the available documentation indicated the FSEP fire plan dated May 16, 2023, included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by the lack of these procedures in the FSEP. During an interview on July 17, 2024, at 3:40 p.m., DM-E stated they thought these procedures were available in the nurse office on the second floor. During an observation on July 17, 2024, at 3:45 p.m. survey staff observed the nurse office on the second floor was locked. The FSEP was not readily available at all times within the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by the lack of training documentation. During an interview on	0 810		

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0 810	Continued From page 9 July 17, 2024, at 3:50 p.m., DM-E stated employees were trained on the facility FSEP upon hire and provided a new hire training record dated July 12, 2024. No additional employee FSEP training documents were provided. DM-E explained they did not have access to these records. DM-E stated they would ask the employee responsible for maintaining employee training records to email this documentation to survey staff tomorrow, as this employee had already left for the day. Survey staff did not receive an email with FSEP employee training records as of July 19, 2024. Training records were not available to support employee training on the FSEP had been completed at the frequency required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (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	01470		

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01470	Continued From page 10 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01470		

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01470	Continued From page 11 Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living, including all required content, for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on March 22, 2022, to provide direct care services to residents. ULP-D's training record included the following: -overview of assisted living statute; -review of providers policies and procedures of and -handling emergencies and using emergency services. ULP-D's employee record lacked documentation the following orientation topics were completed: -reporting maltreatment of vulnerable adults or minors; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -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		

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(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; -handling of resident complaints, reporting of complaints, where to report; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning/services deliver. On July 16, 2024, at 12:37 p.m., clinical nurse supervisor (CNS)-B stated they utilize healthcare acadamy; a training educational system for staff training and human resources oversees all staff training records. CNS-B stated they were unaware of the missing requirements for ULP-D's orientation and provided surveyor with ULPD's record of history for all educational training. No further information was provided.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34338	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT FOLEY AL LLC	120 NORMAN AVENUE SOUTH FOLEY, MN 56329

(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
01500	Continued From page 13 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34338	A. BUILDING: _____ B. WING _____	07/19/2024

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01500	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff that perform direct services completed at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). 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: ULP-D began employment on March 22, 2022. ULP-D's record lacked evidence annual training had been completed as required in the following area: - principles of person-centered planning/service delivery. On July 16, 2024, at 12:37 p.m., clinical nurse supervisor (CNS)-B stated they utilize healthcare academy; a training educational system for staff training and human resources oversees all staff training records. CNS-B stated they were unaware of the missing requirements for ULP-D's training record and provided surveyor with ULPD's record of history for all educational training. The licensee's Required Annual Staff Training	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34338	A. BUILDING: _____ B. WING _____	07/19/2024

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01500	Continued From page 15 policy dated November 2021, indicated all staff providing direct assisted living services would complete a minimum of eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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	34338	A. BUILDING: _____ B. WING _____	07/19/2024

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01530	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee received eight hours of initial dementia care training within the first 160 working hours of the employment start date for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired March 22, 2022, to provide direct care services to the assisted living residents. ULP-D's employee record contained two (2) hours of Cognitive Impairment: Advanced. ULP-D's employee record lacked the required initial dementia training in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On July 16, 2024, at 12:37 p.m., clinical nurse supervisor (CNS)-B stated they utilize healthcare	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34338	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01530	Continued From page 17 academy; a training educational system for staff training and human resources oversees all staff training records. CNS-B stated they were unaware of the missing requirements for ULP-D's training record and provided surveyor with ULPD's record of history for all educational training. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	01770		

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	34338	A. BUILDING: _____ B. WING _____	07/19/2024

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01770	Continued From page 18 The findings include: R2's Progress Note dated July 8, 2024, at 8:40 a.m. stated "Medications set up through 7/21/2024." R2's record lacked medication set-up documentation to include name of medication, quantity of dose, times to be administered, routes of administration, and name of person completing medication set-up. On July 16, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated when they completed a medication set-up, they just write a progress note and was not aware of all the documentation requirements for medication set-ups. The licensee's Medication Administration-Documentation policy dated November 11, 2019, indicated the licensed nurse would set up medications on weekly basis and document after task has been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *07/15/24*
Time: 11:00:32
Report: 1037241146

Food and Beverage Establishment Inspection Report

Location:
The Gardens at Foley Assisted
120 Norman Avenue South
Foley, MN56329
Benton County, 05

Establishment Info:
ID #: 0010261
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
The Gardens at Foley Assisted

Phone #: 3209686425
ID #: 53451

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

COOKED HOT DOG ON COUNTERTOP MEASURED 87F. DISCARD AND HOLD COOKED TCS FOODS AT 135 OR ABOVE.

Comply By: 07/15/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COTTAGE CHEESE AND MILK MEASURED 43 AND 44 RESPECTIVELY. ADJUST UNIT COLDER TO MAINTAIN A TEMP OF 41 OR BELOW.

Comply By: 07/15/24

3-700 Contaminated Food: discarded

3-701.11A ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

DISCARD IMPROPERLY HOT HELD HOT DOG THAT MEASURED 87F.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER MEASURED 150.1F AT TIME OF INSPECTION. REPAIR OR REPLACE DISHWASHER. CAN BE USED FOR WASH AND RINSE BUT MUST BE SANITIZED IN THE NURSING HOME KITCHEN.

Comply By: 07/15/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

BULK CEREAL AND HOT COCOA CONTAINERS DID NOT BEAR LABELS. LABEL CONTAINER WITH CONTENTS WHEN REMOVED FROM ORIGINAL PACKAGING.

Comply By: 07/15/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI WIPE BUCKET
Violation Issued: No

Hot Water: = at 150.1 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: COTTAGE CHEESE
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: MILK
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	0	1

DISCUSSED HOW FOOD IS HANDLED: FOOD IS COOKED/PREPPED IN NURSING HOME KITCHEN, AND IS BROUGHT OVER TO ASSISTED LIVING KITCHENETTE FOR SERVING.

DISCUSSED DISH WASHING METHODS TO USE IN PLACE OF BROKEN DISHWASHER. A REPLACEMENT DISHWASHER IS TO BE INSTALLED IN THE NEXT FEW WEEKS.

Type: Full
Date: *07/15/24*
Time: 11:00:32
Report: 1037241146
The Gardens at Foley Assisted

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037241146 of 07/15/24.

Certified Food Protection Manager: Jeanne Lee Wagner

Certification Number: 109595 Expires: 02/04/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1037241146

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	4
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/15/24
Time In 11:00:32
Time Out

The Gardens at Foley Assisted	Address: 120 Norman Avenue South	City/State: Foley, MN	Zip Code: 56329	Telephone: 3209686425
License/Permit #: 0010261	Permit Holder: The Gardens at Foley Assisted	Purpose of Inspection: Full	Est Type:	Risk Category: L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	(N/A)	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	(N/A)	N/O	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	IN	(OUT)			Proper disposition of returned, previously served, reconditioned, & unsafe food	X	

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	(OUT)	N/A	N/O	Proper hot holding temperatures		
22	IN	(OUT)	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water			COS	R
30	IN OUT (N/A)	Pasteurized eggs used where required				
31		Water & ice obtained from an approved source				
32	IN OUT (N/A)	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding				
35	IN OUT N/A (N/O)	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37	X	Food properly labled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present				
39		Contamination prevented during food prep, storage & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				

		Proper Use of Utensils			COS	R
43		In-use utensils: properly stored				
44		Utensils, equipment & linens: properly stored, dried, & handled				
45		Single-use/single service articles: properly stored & used				
46		Gloves used properly				
Utensil Equipment and Vending						
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48		Warewashing facilities: installed, maintained, & used; test strips				
49		Non-food contact surfaces clean				
Physical Facilities						
50		Hot & cold water available; adequate pressure				
51		Plumbing installed; proper backflow devices				
52		Sewage & waste water properly disposed				
53		Toilet facilities: properly constructed, supplied, & cleaned				
54		Garbage & refuse properly disposed; facilities maintained				
55		Physical facilities installed, maintained, & clean				
56		Adequate ventilation & lighting; designated areas used				
57		Compliance with MCIAA				
58		Compliance with licensing & plan review				

Food Recalls:

Person in Charge (Signature) **Date:** 07/15/24

Inspector (Signature)