DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 1, 2023

Administrator
The Gardens At Foley LLC
253 Pine Street
Foley, MN 56329

RE: CCN: 245325
Cycle Start Date: September 12, 2023

Dear Administrator:

On October 23, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered
September 29, 2023

Administrator
The Gardens At Foley LLC
253 Pine Street
Foley, MN 56329

RE: CCN: 245325
Cycle Start Date: September 12, 2023

Dear Administrator:

On September 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 12, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

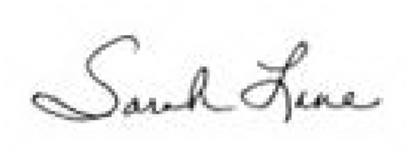
specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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Minnesota Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT FOLEY LLC	253 PINE STREET 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) COMPLETION DATE
E 000	Initial Comments On 9/10/23 through 9/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff	E 015		10/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/04/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 015	Continued From page 1 and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure policies and procedures included	E 015	-The process for satisfying this requirement has been reviewed and	

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E 015	Continued From page 2 the provision of subsistence needs for alternate sources of energy to maintain freezer and cooler temperatures for the safe storage of provisions. This practice had the potential to affect 70 current residents who depended on the facility for their nutritional needs. Findings include: On 9/11/23, the Life Safety Code surveyor identified the backup generator was not connected to supply energy to the kitchen coolers and freezer to ensure food was kept safe at the proper temperature if the facility lost power. During interview on 9/11/23 at 1:13 p.m., the facility administrator (ADM) stated they were aware the coolers and freezers were not connected to the emergency power generator, and there was no other secondary source for power to the food storage units. In review of the facility document, entitled: The Gardens at Foley Emergency Operations Program and Plan Manual (undated) sub-section 3.6 Subsistence Needs for Staff and Patients indicated the following: "Our facility has a robust supply of emergency and materials (see Shelter in Place [policies and procedures], Disaster Supply Inventory Appendix E and Disaster Meal Menus Appendix). We have a system for shelf-life management that includes rotation through the usual stock, and established agreements with a variety of vendors for our re-supply and recovery needs (see Vendor list - Emergency Agreements - Appendix V). The oven has a gas supply source. In a review of the facility's policy, entitled: Power Outage (reviewed 5/30/23) included "take	E 015	revised as needed to ensure The Gardens at Foley (GAF) has alternative measures in place to ensure provisions are safely maintained. -All residents who are dependent on the facility for nutritional needs have the potential to be affected if this requirement is not met. -GAF Maintenance Director is obtained a quote from a qualified vendor to supply emergency backup power to the current culinary refrigerator and freezer. Executive Vice President obtained verbal agreement with Thermo King to provide refer trailer in the event of an emergency. -GAF Administrator and Regional Director of Operation is working with Monarch Healthcare Management to obtain an agreement to have alternative refrigeration and/or freezer services brought on-site in the event of alternate energy sources being required. -GAF safety committee and/or QAPI team will review and revise the Emergency Operations Plan (EOP) as needed to reflect changes that meet this requirement. -All GAF staff will be provided education on this requirement - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be	

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E 015	Continued From page 3 reasonable steps to protect food, water supplies, and maintain a safe environment for the residents and staff."	E 015	identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 10/20/23.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		9/29/23

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E 041	Continued From page 4 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a	E 041		

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E 041	Continued From page 5 document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility.	E 041	-An area for improvement was identified when, upon document review, there was no evidence to support the facility completed a 4-hour load bank test in the past 36-months. -Failure to meet this requirement has the potential to have a widespread impact on residents within the facility.	

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E 041	Continued From page 6 Findings include: On 09/11/2023 at 9:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	E 041	-The Maintenance Director has been educated to the requirement and the identified area of concern has been corrected. -An approved vendor was on-site on 9/29/23 and completed the 4-hour load bank test. -Corrective action is completed and the requirement is met for 36-months. -Corrective action will be reviewed at QAPI with any area of concern immediately addressed. -Maintenance Director or designee is responsible party. -Corrective action was completed on 9/29/23.	
F 000	INITIAL COMMENTS On 9/10/23 through 9/12/23 a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed, found in complainance, with NO deficiencies cited: H53255287C (MN00096594). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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F 000	Continued From page 7 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in accordance with professional standards of practice for 1 of 1 residents (R63) reviewed for catheter cares. Findings include: R63's admission record dated 9/12/23, identified diagnoses included urinary tract infection, Parkinson's disease, mild cognitive impairment, and neuromuscular dysfunction of bladderBased on Observation, interview, and record review, the facility failed to comprehensively assess 1 of 2 residents (R10) for safe use of a lighter.	F 684	-The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are provided catheter care in accordance with professional standards. -All residents in the facility who have a catheter and rely on staff for catheter care have potential to be affected if this requirement is not met. -All residents who have a catheter and receive catheter care by qualified staff are reviewed at minimum 2x per day according to professional standards of	10/20/23

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F 684	Continued From page 8 R10's significant change Minimal Data Set (MDS) dated 8/11/23, indicated intact cognition and diagnoses of anxiety, bipolar (highs and lows in mood), schizophrenia (distorted sense of reality). R10's face sheet indicated admission date on 3/30/23, tobacco user and nicotine dependence. R10 smoking assessment dated 9/5/23, indicated current smoker able to hold and light own cigarettes and used a smoking apron. Facility assessment lacke evidence R10 had been assessed to safely keep cigarette lighter on his person. On 9/11/23 at 9:36 a.m., R10 was smoking out in designated area. He came back into facility and kept the lighter on his person. On 9/11/23 at 10:05 a.m., R10 was in his room and stated he had just gone out to smoke. He kept the lighter on him until he was done smoking for the day. On 9/11/23 at 1:36 a.m., R10 was in smoking area. He returned with lighter on his person. On 9/12/23 at 8:25 a.m., certified nursing assistant (CNA)-D stated he had worked with R10 and was aware R10 smoked. CNA-D stated R10 kept the lighter in his room. On 9/12/23 at 8:55 a.m., CNA-E stated she was aware R10 went outside to smoke. He wore an apron and got his cigarettes and lighter from the nurses. CNA-E stated R10 kept the lighter on him throughout the day. On 9/12/23 at 12:09 a.m., registered nurse	F 684	practice. -R63□s order summary and plan of care was reviewed and revised as needed to reflect any required changes. -Necessary clinical staff have received education using Monarch Healthcare Management Policy and Procedure. -Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 10/20/23	

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	245325	A. BUILDING _____ B. WING _____	C 09/12/2023

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F 684	Continued From page 9 (RN-B) stated R10 smoked a lot. He got the cigarettes and lighter from the nursing staff. R10's smoking supplies were kept in the cart. On 9/12/23 at 12:15 p.m., registered nurse (RN-A) stated she was the unit manager. R10 had a smoking assessment. RN-A stated the assessment lacked identification R10 was appropriate to keep the lighter on his person. Facility document, titled, Resident Smoking Policy indicated that storage of supplies varies depending on resident's cognitive abilities and s best left to the facility to individualize based on the resident's smoking assessment. R63's care plan dated 8/25/23, indicated need for staff assistance with toileting and Foley catheter cares per policy. R63's order summary report dated of 9/12/23, indicated staff was to clean insertion site daily with soap and water. The orders lacked direction for use of skin prep. During observation and interview on 09/12/23 at 7:25 a.m., nursing assistant (NA)-A provided R63's catheter cares. After NA-A washed R63's indwelling catheter with soap and water, she applied skin prep to the penis around the catheter insertion site. NA-A stated she was directed by the previous unit manager to apply skin prep to male residents with catheters. NA-A was unsure if a policy indicated the use of skin prep for catheter care. On 9/12/23 at 1:26 p.m., licensed practical nurse (LPN)-C stated NA-A got a skin prep pad to	F 684		

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F 684	Continued From page 10 complete catheter cares. These were stored on medication cart. LPC-C removed a No Sting Skin Prep pad from the locked medication cart to indicate the product used. LPN-C stated previously the task to utilize skin prep was on the treatment administration record (TAR) and a nurse completed the skin prep application following catheter cares provided by a NA. On 9/12/23 at 10:40 a.m., registered nurse (RN)-A stated skin prep for catheter care was not a standard practice and she was unaware of any such changes to the facility catheter policy and procedure. On 9/12/23 at 1:37 p.m., director of nursing (DON) stated standard practice was to use soap and water when catheter care was provided. The facility did not use barrier protection as standard practice. DON stated if a barrier cream or product was needed, the product would be listed on the TAR and a licensed nurse applied the product to ensure the site was monitored by a nurse. The facility's Indwelling Catheter Care Procedure policy dated 7/21/23 identified supplies needed as soap and basin of warm water, two or more washcloths, towel, gloves. The policy did not include the application of barrier products.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/20/23

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F 689	Continued From page 11 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Resident #10 Based on Observation, interview, and record review, the facility failed to comprehensively assess 1 of 2 residents (R10) for safe use of a lighter. R10's significant change Minimal Data Set (MDS) dated 8/11/23, indicated intact cognition and diagnoses of anxiety, bipolar (highs and lows in mood), and schizophrenia (distorted sense of reality). R10's face sheet indicated admission date on 3/30/23, tobacco user and nicotine dependence. R10 smoking assessment dated 9/5/23, indicated current smoker able to hold and light own cigarettes. Used a smoking apron. Facility assessment lacked evidence R10 had been assessed to safely keep cigarette lighter on his person. On 9/11/23 at 9:36 a.m., R10 was smoking in designated area. He came back into facility and kept the lighter on his person. On 9/11/23 at 10:05 a.m., R10 was in his room and stated he had just gone out to smoke. He kept the lighter on him until he was done smoking for the day. On 9/11/23 at 1:36 a.m., R10 was in smoking area. He returned with lighter on his person.	F 689	-The process for satisfying this requirement has been reviewed and revised as needed to ensure residents who smoke are assessed for safe use of a lighter. -All residents in the facility who smoke have the potential to be affected if this requirement is not met. - R10 was reassessed and deemed safe to independently use a lighter. His care plan was reviewed and revised as necessary. In accordance with resident rights and the facility smoking policy, R10 is allowed to keep his lighter during daylight hours and it must be turned back into the Charge Nurse each evening. -All residents who smoke have received a new smoking assessment and their care plans have been reviewed and revised as necessary. -GAF staff have received education on the resident smoking policy. GAF clinical staff have received additional education on reviewing orders and the care plan for questions on safe use of lighters. -Audits will be completed three (3) times per week for two (2) weeks; two (2) times	

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F 689	Continued From page 12 On 9/12/23 at 8:25 a.m., certified nursing assistant (CNA)-D stated he had worked with R10 and was aware R10 smoked. CNA-D stated R10 kept the lighter in his room. On 9/12/23 at 8:55 a.m., CNA-E stated she was aware R10 went outside to smoke. He wore an apron and got his cigarettes and lighter from the nurses. CNA-E stated R10 kept the lighter on him throughout the day. On 9/12/23 at 12:09 a.m., registered nurse (RN-B) stated R10 smoked a lot. He got the cigarettes and lighter from the nursing staff. R10's smoking supplies were kept in the cart. On 9/12/23 at 12:15 p.m., registered nurse (RN-A) stated she was the unit manager. R10 had a smoking assessment. RN-A stated the assessment lacked identification R10 was appropriate to keep the lighter on his person. Facility document, titled, Resident Smoking Policy indicated that storage of supplies varies depending on resident's cognitive abilities and s best left to the facility to individualize based on the resident's smoking assessment.	F 689	per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 10/20/23	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		10/20/23

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F 755	Continued From page 13 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records review, the facility did not ensure safe disposition of controlled substances for 1 of 3 residents (R1, R9 and R28) reviewed for medication management. Findings include: R28's minimum data set (MDS) history showed an admission date of 1/21/22. The MDS indicated primary diagnoses of non-traumatic brain dysfunction. The medication orders for R28 included lorazepam 0.25 mL (milliliters) by mouth	F 755	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure qualified GAF staff properly destroy medications classified as controlled substances in accordance with pharmacy policy and procedure. -Timely destruction of controlled substances is recommended to avoid the potential for drug diversion. Residents who have medications ordered that are classified as controlled substances may	

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F 755	Continued From page 14 for agitation and anxiety, with a start date of 12/9/22 and discontinued on 2/7/23. The facility's narcotic register showed on page 13 of the index that R28's supply of Lorazepam Intensol Oral Concentrate 2mg(milligram)/mL (milliliter) remained current in the register and was counted with each narcotic count; and the corresponding actual page 13 showing 30 mL of Lorazepam remaining. On 9/12/2023 at 2:28 p.m., licensed practical nurse (LPN)-A verified that the narcotic register showed a stock of 30 mL for R28's Lorazepam, that it was being counted every shift change and remained stored in the narcotic lockbox that was located in the refrigerator in the medication room. LPN stated the bottle would be expired in October 2023. It was a full bottle which contained 30 mL. LPN-A checked R28's orders and confirmed that R28 did not have a current Lorazepam order. During interview on 9/12/23 at 12:54 p.m., the director of nursing (DON) stated when a narcotic order is discontinued or expired that the medication should be removed from the lock box in the refrigerator or from the medication cart, and be placed in the double locked safe that is hung on the wall in the medication room for destruction. It was the unit managers responsibility to monitor and destroy of medications and that medications should be destroyed as soon as possible. DON confirmed the discontinued Lorazepam remained accessible in the locked container in medication fridge. DON expected the medication should have been disposed of by now. During interview on 9/12/23 at 1:40 p.m., the Pharmacist consultant (Pharm-D) stated the	F 755	be affected if this requirement is not met. -R28□s Lorazepam, a controlled substance, that was in questions has been destroyed according to pharmacy policy and procedure -Qualified GAF clinical staff have been educated using pharmacy policy and procedure.¿ - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.¿ -Director of Nursing or designee is responsible party.¿¿ -Corrective action will be completed by 10/20/2023.	

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F 755	Continued From page 15 purpose of a medication to be destroyed in a timely manner would be to prevent diversion of medication. The Lorazepam should have been disposed of by now since that would be best practice. The facility's Discarding and Destroying Medications policy, dated 4/19, indicated that the disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		9/12/23

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F 761	Continued From page 16 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 2 of 3 refrigerators observed in use for medication storage. This had potential to affect 6 of 6 residents (R1, R7, R9, R21, R28 and R28) who received controlled medications. Findings include: On 9/12/23 at 11:14 a.m., a tour of the medication storage room, located on the 100 unit, was conducted with licensed practical nurse (LPN)-A. Medication storage room door was locked, upon entering the medication room, a portable (moveable) refrigerator was observed sitting on top of table. LPN-A unlocked portable refrigerator door and a small, locked container that stored narcotics was observed. LPN-A removed locked container from the door of the refrigerator and placed on the top of refrigerator to unlock. Narcotics container visualized and consisted of 3 boxes of liquid lorazepam (an anti-anxiety medication/controlled substance) prescribed for R1, R9 and R28. Although, the medications were double locked, the narcotic storage container within the refrigerator was not permanently affixed. On 9/12/23 at 12:52 p.m., a tour of the medication storage room, located on the 300, 400, and 500 units, was conducted with LPN-B. Medication storage room door was locked, upon entering the medication room, a portable (moveable) refrigerator was observed sitting on	F 761	- The process for satisfying this requirement has been reviewed and revised as needed, to ensure medications classified as controlled substances are stored in a double locked compartment and permanently affixed in accordance with pharmacy policy and procedure. - Residents who have medications ordered that are classified as controlled substances that require refrigerated needs may be affected if this requirement is not met. -With the supervision of a qualified GAF clinical staff member, Maintenance immediately permanently affixed the storage compartments. -Qualified GAF clinical staff have been educated using pharmacy policy and procedure. -Corrective action is completed and the requirement is met. -Corrective action will be reviewed at QAPI with any area of concern immediately addressed. -Director of Nursing or designee is responsible party.¿¿ -Corrective action was completed on	

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F 761	Continued From page 17 top of medication counter. LPN-B unlocked portable refrigerator door and a small, locked container that stored narcotics was observed. LPN-B removed locked container from the refrigerator and placed on the counter to unlock. Narcotics container visualized and consisted of 3 boxes of liquid lorazepam (an anti-anxiety medication/controlled substance) prescribed for R7, R21 and R51. Although, the medications were double locked, the narcotic storage container within the refrigerator was not permanently affixed. On 9/12/23 at 11:14 a.m., LPN-A confirmed that small, locked container containing narcotics were not permanently affixed inside of the refrigerator. On 9/12/23 at 12:52 p.m., LPN-B indicated awareness that controlled substance medications needed to be stored in an area providing 2 separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. LPN-B confirmed that small, locked container containing narcotics were not permanently affixed inside of the refrigerator. On 9/12/23 at 12:54 p.m., the director of nursing (DON) indicated awareness that controlled substance medications needed to be stored in an area providing two separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. The DON indicated controlled substance medications were kept in facility locked medication storage room, within a locked portable refrigerator, stated she thought process used for controlled medication substance storage was sufficient at time, would	F 761	9/12/2023.¿	

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F 761	Continued From page 18 ensure process for controlled medication storage was corrected immediately so controlled medication storage unit would not be able to leave the refrigerator decreasing the change of diversion. The facility Medication Storage policy dated 1/18, indicated schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications or per state regulation. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		10/20/23

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F 812	Continued From page 19 by: Based on observation, interview and document review, the facility failed to store food in accordance with professional standards for food safety in 1 of 1 unit refrigerators. This had the potential to affect all 20 residents that resided on the unit. Findings include: On 9/12/23 at 11:00 a.m., the refrigerator in the memory care unit included a glass canning jar hand-labeled "blackberry jam 7/17/23", an open bottle of Kefir without an opened on date, an open bottle of Thick 'n Easy thickener without an opened on date, and 15 unlabeled, undated, two-ounce covered clear plastic souffle cups of various condiments (mayonnaise, mustard, ketchup). On 9/12/23 at 11:24 a.m., dietary manager (DM) stated it was the expectation that kitchen staff would check the refrigerator daily for expired and undated food. The DM acknowledged the blackberry jam should have been disposed of 3 days after the open date. The condiments were not dated, nor were the Kefir and thickener. She stated it was important to label refrigerated items and dispose of foods properly to prevent foodborne illnesses. The facility's Food Brought in for Resident's Individual Consumption policy, dated January 2017 specified the container must be labeled with the resident name and the date the item was received, and food must be disposed of properly after 3 days. Refrigerator and freezer cleanliness would be maintained weekly by facility staff.	F 812	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure food is stored and labeled appropriately. - All residents in the memory care unit have the potential to be affected if this requirement is not met. -The food discovered during survey was immediately disposed of. - The policy and procedure necessary to meet this requirement was reviewed and revised as needed to ensure food is properly stored, labeled, and staff are aware of the need to dispose of food appropriately. - Education for necessary GAF staff has been initiated utilizing Monarch Healthcare Management policy and procedures. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Culinary Director or designee is responsible party. - Corrective action will be completed on or before 10/20/23.	

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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) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		10/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 09/12/2023

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THE GARDENS AT FOLEY LLC	253 PINE STREET FOLEY, MN 56329

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F 880	Continued From page 21 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mechanical lifts were disinfected between resident uses. These findings had potential to affect 6 residents residing on the memory care unit who were assited by a mechanical lift. Findings include: On 9/12/23, at 7:08 a.m. R28 was received morning care with two nursing assistants (NA)-B	F 880	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure GAF staff properly disinfect mechanical lifts between use. -Residents residing in this facility who have care provided by qualified GAF nursing staff using mechanical lifts have the potential to be affected if this requirement is not met.	

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F 880	Continued From page 22 and NA-C. After morning care, NA-B and NA-C transferred R28 from the bed to her Broda chair (a wheelchair provide supportive positioning through a combination of positions) using a mechanical lift. Once R28 was positioned appropriately, NA-B removed the mechanical lift from the room and placed it in the storage area down the hall without disinfection. On 9/12/23 at 7:42 a.m., after continuous observation of the stored mechanical lift, NA-B brought the mechanical lift room 107 to assist R52 in transferring. NA-B stated lifts should be disinfected after each resident use, before storing. NA-B stated he had not disinfected the lift after R28 was transferred. NA-B then disinfected the lift before using it on R52. The facility had an outbreak of COVID-19 in the last 30 days, and had just taken the last resident off precautions 4 days prior. On the memory care unit, where the observation occurred, of the 20 current resident residing on this unit, 11 resident had tested positive for COVID-19 in the last 30 days. During interview on 9/12/23 at 12:44 p.m., the director of nursing (DON) stated all lifts and standers should be disinfected in between each individual resident use. DON further stated disinfection wipes should be on each lift, and if not in the supply rooms of each unit. In review of the facility's policy, entitled: Cleaning and Disinfection of Resident-care Items and Equipment (last revised October 2021) indicated the following in section 1 -d.: d. Reusable items are cleaned and disinfected or	F 880	-All necessary GAF clinical staff have received re-education on appropriate infection control practices to disinfect lifts between uses. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 10/20/23.	

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F 880	Continued From page 23 sterilized between residents (e.g., stethoscopes, durable medical equipment).	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, report and repair damaged drywall observed in a room on the memory care unit. This had the potentially to affect the resident residing in room 109. Findings include: During interview on 9/10/23 at 12:24 p.m. with R34, resident was sitting in a room recliner which was against the wall. During the interview, R34 was rocking in the recliner which was striking the wall behind him. On closer examination of the wall, it was noted the drywall paper was missing and the inner white gypsum (used in many forms of plaster, drywall and blackboard or sidewalk chalk) was exposed the entire length of the recliner back. In an interview on 9/12/23 at 8:36 a.m., the maintenance director (MAIN) entered R34's room and upon seeing the damaged wall, MAIN stated "oh boy". MAIN stated he was not aware of the damage and stated he missed it himself when he was in the room the day prior to replace batteries in the paper towel dispenser. MAIN stated when staff notice needed repairs, they should report the	F 921	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure GAF staff appropriately identify, report, and repair environmental damage in resident areas. - Failure to meet this requirement had the opportunity to affect the resident residing in room 109. -The damaged area was repaired and is corrected. -All GAF staff have been educated to the requirement to notify maintenance to ensure timely identification and repair of environmental damage in resident areas. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator, Maintenance Director, or	9/29/23

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F 921	Continued From page 24 concerns by email system, notes or verbally information maintenance. Using his hand as a measuring tool, MAIN estimated the wall damage to be approximately 26 inches in length, 3-4 inches in width and 1/4+ inches in depth (into the exposed gypsum board. In review of the last 30 days or repair reports, room 109 was not documented as being reported to the maintenance department. A review of the facility's policy, entitled: Maintenance Services (revised December 2009) indicated only the responsibility of the maintenance department. The policy received lacked mention on how the facility staff were to report repair concerns other than: "8. The Maintenance Director is responsible for maintaining the following records/ reports. k. Inspection of building; l. Work order requests; m. Maintenance schedules; n. Authorized vendor listing; and o. Warranties and guarantees."	F 921	designee is responsible party. -Corrective action is completed, effective 9/29/23.	

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	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Federal Recertification Life Safety Code Survey was conducted on 09/11/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Gardens at Foley was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/04/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as 1 building: The Gardens at Foley is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1970 and was determined to be of Type II(222) construction. In 1976, an addition was added to the north that was determined to be of Type V(111). In 1994 additions were added to the west of Units 2 & 4, additions to the Kitchen and Dining Room that were determined to be of Type II(000) construction and a Chapel addition to the west of Unit 2 which was determined to be	K 000		

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K 000	Continued From page 2 Type V(111) construction. In 2008 two additions were added to the facility, the North wing determined to be of type II(111) construction and the PT/OT addition determined to be of type II(111). This building is fire sprinkler protected and has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a licensed capacity of 78 beds and had a census of 70 at the time of the survey. The requirements at 42 CR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		9/29/23

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K 918	Continued From page 3 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/11/2023 at 9:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 918	-An area for improvement was identified when, upon document review, there was no evidence to support the facility completed a 4-hour load bank test in the past 36-months. -Failure to meet this requirement has the potential to have a widespread impact on residents within the facility. -The Maintenance Director has been educated to the requirement and the identified area of concern has been corrected. -An approved vendor was on-site on 9/29/23 and completed the 4-hour load bank test. -Corrective action is completed and the requirement is met for 36-months.	

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K 918	Continued From page 4	K 918	-Corrective action will be reviewed at QAPI with any area of concern immediately addressed. -Maintenance Director or designee is responsible party. -Corrective action was completed on 9/29/23.	