DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 8, 2024

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

Re: Reinspection Results
Event ID: LXG212

Dear Administrator:

On September 11, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 8, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2024

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

RE: CCN: 245325
Cycle Start Date: August 8, 2024

Dear Administrator:

On September 13, 2024, we notified you a remedy was imposed. On September 11, 2024 and October 7, 2024 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 27, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 8, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 27, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2024

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

RE: CCN: 245325
Cycle Start Date: August 8, 2024

Dear Administrator:

On August 8, 2024, 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, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 November 8, 2024 (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 February 8, 2025 (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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 08/08/2024

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 8/5/24 to 8/8/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/5/24 through 8/8/24, 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 complaints were reviewed with NO deficiencies cited: H53256600C (MN00104215). 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 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	Quality of Care	F 684		9/6/24

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

Electronically Signed | 08/29/2024

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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F 684 SS=D	Continued From page 1 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 ensure appropriate wheel chair (WC) positioning was maintained for 1 of 2 residents (R45) in the sample reviewed for positioning. Findings include: R45's most current quarterly minimum data set (MDS), dated 5/20/24, documented R45 was severely cognitively impaired and was dependent with most of his activities of daily living. R45's Medical Diagnosis sheet printed 8/7/24, indicated diagnoses of morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease, and dementia with other behavioral disturbances. During observation on 08/05/24 at 2:28 p.m., R45 was observed in his WC. near the central dayroom. R45 was a sleep, leaning back in his WC. The vinyl back of the WC lined up with R45's mid-back, which when sleeping, caused R45 to be arched over the back of the WC. When R45 leaned back, the vinyl back was pushed down	F 684	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible	

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F 684	Continued From page 2 approximately two inches. During breakfast observation on 8/6/24 at 8:57 p.m., R45 was finishing his breakfast, as he was leaning back in his WC. R45 stated he was "sore" today. He had pain in his back. During observation on 8/07/24 at 7:45 a.m., R45 was again observed sitting at a dining room table sleeping, leaning back in his WC. R45 was leaning so much, he was facing the ceiling and snoring. The vinyl back appeared to be pressed down approximately two inches down mid-back. R45 was in such a reclined position, resident's shoulders and head were over the back support of his WC. R45's medical records indicated R45 was last seen by occupational therapy in September 2023. An evaluation (screened) for needs was completed, however it was decided R45 did not require any treatment or interventions at that time. During observation and interview on 8/8/24 at 9:58 a.m., R45 was sitting in his WC next the the family room on the unit, sleeping and leaning back. The contracted occupational therapist (OTR) performed a brief visual screen of R45. OTR stated, although R45's WC was wide enough in the seat, the back was too narrow and too short, which was not providing sufficient support for R45. OTR stated she had only been at the facility for a couple of months, and had never worked with R45, nor was informed of any WC issues with R45. A review of the facility's policy, entitled: Activities of daily Living (ADLs) / Maintain Abilities Policy	F 684	allegation of compliance. F684 s/s D - The process for satisfying this requirement has been reviewed and revised as needed, to ensure appropriate wheelchair (w/c) positioning is maintained for positioning for R45 - All current, alike residents, who have been identified have the potential to be affected if this requirement is not met. - R45 was immediately evaluated by Select Therapy and a different w/c was provided. - Select Therapy is working with an outside vendor, for mobility equipment, to review, size, and/or fit R45 for a new w/c. -Alike residents were reviewed and evaluated by therapy services as required. - Appropriate GAF staff have been re-educated to this requirement utilizing Monarch Healthcare Management policy and procedure. - Audits will be completed to ensure compliance with this requirement. 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 9/06/2024.	

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F 684	Continued From page 3 (last updated 5/9/24) documented the following: "1. Based on a comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living to not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable." 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living."	F 684		
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 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	F 755		9/6/24

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F 755	Continued From page 4 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 observation, interview and document review, the facility failed ensure medications were administered safely for 3 of 6 residents (R19, R40, R61) reviewed for medication administration. Findings include: During observations on 8/7/24 at 9:29 a.m., trained medication aide (TMA-D) stood by a medication cart outside the dining room. TMA-D opened the top drawer of the cart and three medication cups were observed in the front compartment. Each cup had an unidentified number of pills of varying size and colors. A small slip of paper approximately the size of a postage stamp was on top of each medication cup and identified the initials for R19, R40, and R61. TMA-D stated they had been instructed to dish up three residents' medications at a time and to document each medication as administered in the electronic medical record (EMR). TMA-D would then administer the medications to the residents. Review of the EMR indicated TMA-D had signed off R19's, R40's, and R61's morning medications, however, the medications had not been	F 755	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible	

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F 755	Continued From page 5 administered. TMA-D confirmed the medications had not been given. On 8/7/24, at 9:50 a.m., TMA-D opened the medication cart drawer, removed the prefilled medication cups for R19 in their room. Moments later, TMA-D exited R19's room without the medications. On 8/7/24, at 9:56 a.m., TMA-D obtained the medication cup for R61 and entered R61's room. Moments later TMA-D exited R61's room without the medication. During interview on 8/7/24 at 10:51 a.m., the director of nursing (DON) stated the staff were to dish up one resident's medications at a time, administered them to the resident and then sign the EMAR after the resident had received the medication. This was to ensure each resident received their medications. Pre-dishing medications was not an acceptable practice and put the residents at risk for potential medication errors. The Medication Administration -General Guidelines policy dated December 2019, directed authorized staff to ensure medications were administered as prescribed in accordance with the five rights of medication administration. The five rights were identified as: right resident, right drug, right dose, right time and right route. The policy also directed medications administered by mobile medication cart were to be taken to the resident's location and medications were to be administered at the time they were dispensed. The policy specifically directed the staff to refrain from pre-pouring medications in advance of the medication pass or for more than one resident at	F 755	allegation of compliance. F755 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure medications are safely administered to residents. -R19, R40, and R61 were safely provided medications. -Residents residing in the facility who receive medications are potentially affected if this requirement is not met. -Necessary GAF staff have been re-educated utilizing Medication Administration policy and procedure. - Audits will be completed to ensure compliance with this requirement. 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 9/06/2024.	

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F 755	Continued From page 6 a time.	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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drops were labeled for specific resident or dated with "opened on" date to ensure expired products were not administered for 2 of 2 residents (R8, R16) reviewed for medication storage and labeling.	F 761	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other	9/6/24

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F 761	Continued From page 7 Findings include: During observation on 8/7/24 at 07:12 a.m., a review of the medication carts was performed with licensed practical nurse (LPN-A). The top drawer of the 500 wing cart contained two open multidose bottles of artificial tears. Neither bottle identified the resident to whom the medication was to be given to, the date the bottle had been opened or a date which would indicate when the medication would expire. LPN-A stated the bottles were stock medications which had been opened for R8 and R16 as they were located in a individually divided sections of the cart for R8 and R16. During interview on 8/7/24 at 09:06 a.m., LPN-A stated staff used all stock medications for things like eye drops and staff could check on the electronic medication record (EMR) to clarify the medication was on the resident's medication list. LPN-A stated staff should be putting an "opened on" and "expiration date" sticker on the bottle. LPN-A then instructed trained medication aide (TMA)-C to place an "opened 8/7/24" on R16's bottle. TMA-C did as directed and dated R16's bottle as 8/7/24, however, the exact date of when the bottle was opened was unknown. During interview on 8/7/24 at 10:51 a.m., director of nursing (DON) stated staff should use facility supply of artificial tears which were packaged in individual dose vials. DON stated the facility supply box is dated with an "Opened on" and "Expires on" sticker. The DON's expectation of staff was to have them use individual dose vials and follow the open date and expiration dates written on the containers to ensure the residents did not receive expired medications.	F 761	individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F761 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure qualified GAF staff properly label / date prescribed eye drop medication in accordance with pharmacy policy and procedure. -Residents residing in the facility who receive eye drop medications from qualified GAF staff have the potential to be affected if this requirement is not met. -Qualified GAF staff, including, but not limited to LPN-A, have been educated to the Medication Storage policy and procedure. -In accordance with policy and procedure, GAF reviewed and revised the process as necessary to ensure that eye drop	

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	245325	A. BUILDING _____ B. WING _____	C 08/08/2024

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F 761	Continued From page 8 The Medication Storage in the Facility policy dated January 2018, indicated when the original seal of a manufacturers container or vial is initially broken, the container or vial will be dated. The nurse will place a "date opened" sticker on the medication and enter the date opened and the new date of expiration, noting the best stickers affix contain both a "date opened" and "expiration" notation line. The policy directed the expiration date to be identified as 30 days from the time the medication was opened.	F 761	medications are dated and labeled appropriately for residents when opened, including the residents name. - Audits will be completed to ensure compliance with this requirement. 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 9/06/2024.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements.	F 851		9/6/24

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F 851	Continued From page 9 The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to submit complete and accurate direct care staffing information, including	F 851	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of	

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F 851	Continued From page 10 information for agency and contract staff, during 1 of 1 quarters (Quarter 2: January 1 - March 31, 2024), reviewed for payroll based journal (PBJ) for excessively low weekend staffing. Findings include: Review of the staffing schedules and timecard verifications with the facility for Quarter 2 identified the facility had licensed nursing staff, 24 hours per day 7 days per week, and 8 consecutive hours per 24 hours of registered nurse (RN) coverage documented. Observations during the facility's recertification survey (8/5/24 through 8/8/24) quality of care was observed. Residents were all dressed and groom well, call lights were answered within acceptable time frames. In further review of the facility's weekend schedules, during the quarter triggered by the facility's PBJ report, it was noted that several of the weekends had two extra staff scheduled, even though there were floats scheduled to assist staffing levels normally scheduled. The extra staff scheduled were not listed as being in training, as noted on other schedules reviewed. Schedules during the same quarter indicated, weekdays matched the weekends where the extra staff were not scheduled. During interview on 8/8/24 at 9:30 a.m., the director of nursing (DON), corporate registered nurse (CRN), corporate nurse lead (prior DON - CNL), the administrator in training (AT) and human relations (HR) were present. CRN stated that HR works with corporate in gathering the the	F 851	Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F851 s/s F -The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility submits to CMS complete and accurate direct care staffing information each quarter. -This had the potential to affect all residents, staff, and visitors -The facility will submit complete and accurate PBJ data in future quarters. -Necessary GAF staff have been reeducated to the requirement and regulation utilizing the CMS submission	

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F 851	Continued From page 11 facility's staffing information for submission in the PBJ report. HR stated the only information HR was responsible to gather is that of agency staff and contractual staff. HR stated corporate utilized the payroll system for gathering facility staff hours. HR only submited non-facility staff to corporate for inclusion for the PBJ. CNL, who had been the director of nursing during the quarter in question, stated the scheduler at that time, had over scheduled on some weekends. CNL stated the scheduler, when there were open shifts, would first schedule agency staff. When staff would then volunteer, many times, scheduler would forget to cancel the agency staff. This may have been why some weekends appeared more heavily scheduled. In review of the facility's policy, entitled: Payroll Based Journal Policy (undated) documented the following: "Payroll Based Journal Staffing Data Submissions are to be completed by all of Monarch Healthcare Management's Long-Term Care Facilities. Monarch follows the Federal Policy Manual created by the Centers for Medicare & Medicaid Services in regards to Electronic Staffing Data Submission Payroll-Based Journal. Monarch's Staffing data is generated and exported from out SmartLinx Scheduling Software and the imported into CMS according to the Submission guidelines provided by CMS. Submissions are to be completed by the Due data for the correct Fiscal Quarter according to the deadlines provided from the Centers for Medicare & Medicaid Services."	F 851	guide and Monarch Healthcare Management PBJ submission guide. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed by 9/06/2024.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/6/24

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F 880	Continued From page 12 §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: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 13 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 record review, the facility failed to follow infection control practices for administration of eye drops to 1 of 2 residents (R16) reviewed for administration of eye drops. Findings include: On 8/7/24 at 8:59 a.m., during an observation of medication administration, trained medication aide (TMA-C) approached R16 and informed R16 it was time for administration of artificial tears.	F 880	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by	

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F 880	Continued From page 14 TMA-C donned a glove and gently pulled the inner corner of R16's left lower lid down and attempted to place one drop in the inner aspect of the lower lid. R16 squeezed their eyes shut. TMA-C gently touched the tip of the medication bottle to the inside of R16's lower left lid. TMA-C then repeated the process for the right eye. TMA-C stated they were unaware the bottle had touched R16's eye lid while administering the medication. TMA-C confirm if the bottle was contaminated during administration, it should no longer be utilized as TMA-C placed the bottle back into the medication cart. During an interview 8/7/24 at 10:51 a.m., the director of nursing (DON) stated the staff were to follow proper infection control and medication administration practices during eye drop administration. This would include ensuring the tip of the bottle did not touch the resident's eye lid. DON confirmed if the eyelid was touched with the bottle, the entire bottle would be considered contaminated and should be discarded. The Specific Medication Administration Procedures -Eye Drop Administration policy dated December 2019, directed the staff to ensure the tip of the dropper does not touch the eye or any other surface".	F 880	the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F880 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure GAF staff use proper practices for administration of eye drops. -Residents residing in this facility who received eye drops by TMA-C have the potential to be affected if eye drop administration is not performed in accordance with policy and procedure. -R16 was assessed by qualified GAF staff and there were no adverse effects. -TMA-C received education on eye drop administration utilizing policy and procedure on eye drop administration (as noted below). -Necessary GAF staff received education utilizing Polaris Pharmacy Eye Drop Administration procedure, which includes, but is not limited to, not allowing the administration device to touch the eye. - Audits will be completed to ensure	

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F 880	Continued From page 15	F 880	compliance with this requirement. 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 9/06/2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: LXG211

Dear Administrator:

The above facility was surveyed on August 5, 2024 through August 8, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/5/24 to 8/8/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H53256600C (MN00104215). NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		8/29/24

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21426	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing was completed for 1 of 5 residents (R67) reviewed for TB testing. Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed all residents and staff must receive a baseline TB screening which should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. R67's Admission Record dated 8/8/24, included an admission date of 5/8/24. R67 diagnosis information included a diagnosis of Alzheimer's disease, major depressive disorder, anxiety disorder, delusional disorders and malnutrition. R67's Treatment Administration Record (TAR) for 5/1/24 to 5/31/24, included a treatment to complete the 2nd step Mantoux and record the results in the chart under the immunization tab. On 5/21/24 had an empty box where the results were to be documented. During interview on 8/7/24 at 11:35 a.m., registered nurse (RN)-A stated she completed TB tracking for residents and staff. RN-A stated she completed a monthly audit report to track compliance. RN-A confirmed R67 did not have both steps of the 2-step Mantoux completed. RN-A confirmed R67 should have either restarted	21426	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	C 08/08/2024

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21426	Continued From page 3 the 2-step Mantoux process or completed either a chest x-ray or blood test. During interview on 8/8/24 at 10:09 a.m., director of nursing (DON) confirmed a 2 step Mantoux should be completed on every resident upon admission. The DON stated if a Mantoux was given and not read, the process should have started over. The DON stated the unit case manager should have monitored for completion of the Mantoux. The DON stated if the facility was unable to complete the 2-step Mantoux, the physician should be updated and a discussion on other testing options should be completed. Facility policy Tuberculosis Screening and Prevention - Residents dated 7/31/23, included residents would complete TB screening within 72 hours of admission and include a TB risk assessment, symptoms evaluation and TB testing. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.	21426		

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21426	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		

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	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/07/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Federal Recertification Life Safety Code Survey was conducted on 08/07/2024, 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	K 000		

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

Electronically Signed | 08/29/2024

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 IS NOT REQUIRED. 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	K 000		

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K 000	Continued From page 2 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 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 69 at the time of the survey. The requirements at 42 CR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor	K 363		9/6/24

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K 363	Continued From page 3 covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/07/2024 between 11:15 AM and 1:15 PM, it was revealed by observations that the door to resident room 113 did not latch when it was closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	

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K 363	Continued From page 4	K 363	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K363 s/s D - The process for satisfying this requirement has been reviewed and revised as needed to ensure resident room doors close and latch. -In the event of an emergency, all occupants within this compartment had the potential to be affected. - The maintenance Supervisor was re-educated to the requirement upon finding the identified area during the walk through. - Resident room door was immediately repaired and corrected. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Maintenance Director or designee is responsible party. -Corrective action will be completed by 9/06/2024.	