DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: PHTL
Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245325**

2. STATE VENDOR OR MEDICAID NO.
(L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE GARDENS AT FOLEY LLC**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2019**

6. DATE OF SURVEY **07/09/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 78 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, District Supervisor — 07/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 07/23/2021 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**07/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**06201**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**07/14/2021**
(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically delivered
July 23, 2021

CMS Certification Number (CCN): 245325

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 2, 2021 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically delivered July 23, 2021

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

RE: CCN: 245325
Cycle Start Date: May 13, 2021

Dear Administrator:

On July 21, 2021, we notified you a remedy was imposed. This was based on the deficiencies cited by this Department for survey completed on May 13, 2021, and lack of verification of substantial compliance with the Life Safety Code (LSC). We have determined that your facility has achieved substantial compliance as of July 2, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 13, 2021 did not go into effect and is rescinded. (42 CFR 488.417 (b))

In our letter of June 2, 2021, 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 August 13, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 2, 2021, 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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PHTL
Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245325**

2. STATE VENDOR OR MEDICAID NO. (L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE GARDENS AT FOLEY LLC**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **08/01/2019**

6. DATE OF SURVEY **05/13/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 78 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Nicole Sassen HFE - NE II 06/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/12/2021 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 2, 2021

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

RE: CCN: 245325
Cycle Start Date: May 13, 2021

Dear Administrator:

On May 13, 2021, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, 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: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

## 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 August 13, 2021 (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 November 13, 2021 (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

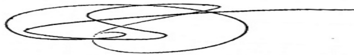
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161     Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc:  Licensing and Certification File

| 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 05/13/2021 |

| 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<br><br>On 5/10/21-5/13/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance with Appendix Z.<br><br>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<br><br>On 5/10/21-5/13/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED however NO deficiencies were cited due to actions implemented by the facility prior to survey:<br>MN70462 H5325034C<br>MN56068 H5325036C<br>MN54243 H5325039C<br>MN72578 H5325040C<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>MN51864 H5325032C<br>MN61026 H5325033C<br>MN70231 H5325035C<br>MN52272 H5325037C<br>MN67455 H5325038C | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/11/2021

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.

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other | F 578 | | 7/2/21 |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 578 | Continued From page 2<br>entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to ensure resident resuscitation wishes were clearly identified in the electronic medical record based on signed advanced directive for 2 of 22 residents (R55 and R56) reviewed for advanced directive.<br><br>Findings include:<br><br>R56's Order Summary Report dated 5/10/21, indicated R56's advanced directive was to resuscitate (CPR-cardiopulmonary resuscitation) or Full Code and ok to follow signed Provider Orders for Life-Sustaining Treatment (POLST)-DNR (do not resuscitate).<br><br>R56's current signed POLST dated 4/20/21, indicated do no attempt resuscitation/DNR.<br><br>On 5/10/21, at 6:56 p.m. licensed practical nurse (LPN)-A stated staff would check the paper chart | F 578 | 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.<br><br>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 | |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|

F 578 Continued From page 3

or the computer for a resident advance directive.

On 5/10/21, at 7:03 p.m. RN-A stated staff should check the chart first to find the residents advanced directive. RN-A stated the chart is the most up to date. RN-A stated once the physician signed the POLST the computer should have been updated.

R55's code status in the care profile section of Point Click Care (PCC) was empty. R55's current signed Provider Orders for Life-Sustaining Treatment (POLST) dated 1/13/21, indicated do not attempt resuscitation/DNR. Additionally, R55's care plan indicated current code status DNR, initiated 4/27/21.

During an interview on 5/10/21, at 6:56 p.m. registered nurse (RN)-B stated resident code status would be determined by looking in the computer or the paper chart. RN-B stated she would look at the POLST in the paper chart to verify resident code status. RN-B stated that if there was a discrepancy, she would follow the directions indicated on the POLST.

During an interview on 5/13/21, at 2:19 p.m. the director of nursing (DON) stated when a POLST was initiated or updated, the POLST would be placed in the front of the paper chart, the code status would be added to physician orders in PCC, the POLST would be scanned into the electronic medical record (EMR), and the code status would be initiated/updated in the resident care plan. The DON further stated that the code status physician order would be entered in by the health unit coordinator (HUC), floor nurse or nurse manager and code status in the care profile

F 578

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.

F578

-The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident resuscitation wishes are clearly identified in the electronic medical record based on the signed advanced directive.

-All Residents residing in the facility have the potential to be affected if this regulation is not met.

-The electronic medical record for R55 and R56 has been reviewed and updated as needed to reflect the current code status as indicated on the signed advanced directive.

-An audit was completed to ensure no other residents were affected. Processes and procedures were reviewed and revised as needed to ensure future instances are avoided.

-Necessary GAF staff have received training utilizing Monarch Healthcare Management policy and procedure on uploading / updating electronic medical record to reflect Physician's order of supporting Residents' or Residents' Representatives code status wishes.

-Necessary GAF staff have received education regarding where to find and/or locate the current Resident code status in the electronic medical record.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING ______<br>B. WING ______ | C<br>05/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| F 578 | Continued From page 4<br>section in PCC auto-populates once entered to physician orders in PCC. In addition, the DON stated additional training was needed to ensure all staff entered the information in correctly, nurses are expected to find and follow the scanned POLST in EMR or the POLST in the paper chart, and the nurses were trained to refer only to the POLST for code status.<br><br>The facility's POLST Documentation procedure revised 1/29/20, indicated the procedure to enter the physician order into PCC must be followed to ensure the resident and/or resident representative's code status wishes, would be reflected in multiple areas within the EMR to include Care Profile section located under residents' picture in PCC and Point of Care (POC), and on the electronic medication administration record/electronic treatment administration record (EMAR/ETAR). | F 578 | --Audits will be completed five (5) 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.<br>-Director of Nursing or designee is responsible party.<br>-Corrective action will be completed by 7/02/2021. | |
| F 584<br>SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. | F 584 | | 7/2/21 |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 584 | Continued From page 5<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain clean bedside table bases on 4 of 4 residents (R42, R43, R20, R5) reviewed for environmental concerns.<br><br>Findings include:<br><br>During observation on 5/10/2021, at 12:55 p.m. R42 was eating a meal in his room. The base of the bedside table had a silver metal finish with multiple white cloudy dried areas and solid debris. This covered 80% of the visible base. | F 584 | 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 | |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 584 | Continued From page 6<br>During observation on 5/11/2021, at 1:35 p.m. R42 was eating using his bedside table eating a meal. The base of the bedside table had a silver metal finish with multiple white cloudy dried areas and solid debris. This covered 80% of the visible base.<br><br>During observation on 5/12/2021, at 7:50 a.m. R42 was sitting in a recliner. The base of the bedside table continues to be dirty.<br><br>During interview with nursing assistant (NA)-B on 5/12/2021, at 8:15 a.m. NA-B stated the base of the bedside stand "is dirty". NA-B stated housekeeping cleans the bedside stands including the base. NA-B then cleaned the bedside stand base and the silver metal finish was shiny and no longer had a cloudy finish.<br><br>During interview with housekeeping (HK)-A on 5/12/2021, at 8:25 a.m. HK-A stated the bedside stand base was cleaned every Tuesday when the dining room table legs were cleaned. Further, HK-A stated the bedside stand base in resident rooms including those for R43, R20, R5 "are dirty and need to be cleaned" and indicated not all the bedside stand bases were clean the day prior due to a staffing shortage.<br><br>During interview with housekeeping (HK)-B on 5/12/2021, at 2:01 p.m. HK-B stated the units are all "sanitized" monthly which includes the bedside stand base. Further, HK-B stated the expectation is the bedside stand base should be cleaned monthly or when viably soiled.<br><br>During interview with the director of nursing (DON) on 5/12/2021 at 2:12 p.m. the DON stated the expectation is that resident care equipment | F 584 | or the correctness of any conclusions set forth in the allegations.<br><br>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.<br><br>F584<br>-The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident bedside table bases are clean and sanitary.<br>-All Residents residing in the facility have the potential to be affected if this requirement is not met.<br>-Necessary GAF staff have received training utilizing Monarch Healthcare Management policy and procedure on cleaning and disinfection of environmental surfaces, along with appropriate service intervals, and/or to clean when visibly soiled.<br>-Audits will be completed five (5) 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. | |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 584 | Continued From page 7<br>should be cleaned if visibly soiled.<br><br>A policy titled "Standard Precautions" dated 2001, with a revision date of 2018 indicated resident care equipment and environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned. | F 584 | -Environmental Services Director or designee is responsible party.<br>-Corrective action will be completed by 7/02/2021. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 3 residents (R22) reviewed for activities of daily living (ADL) who was dependent on staff for assistance with ADL care.<br><br>Findings include:<br><br>R22's face sheet, printed 5/13/21, indicated R22 diagnoses included unspecified dementia with behavioral disturbance, polyneuropathy, osteoarthritis, anxiety disorder and glaucoma.<br><br>R22's quarterly Minimum Data Set (MDS) dated 3/2/21, indicated R22 was cognitively intact, and required extensive assistance with bed mobility, transfers, dressing and personal hygiene.<br><br>R22's Care Area Assessment (CAA) dated 9/30/20, indicated R22 required extensive staff assistance with grooming. | F 677 | 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.<br><br>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 | 7/2/21 |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 677 | Continued From page 8<br><br>R22's care plan, revised 3/10/21, indicated R22 had an ADL self-care performance deficit due to increased weakness, dementia, and required assist of 1 staff for personal hygiene.<br><br>During an observation and interview on 5/10/21, at 4:41 p.m. R22 was observed to have multiple white hairs on her chin, approximately one-half to one inch in length. R22 confirmed that chin hairs should be shaved by staff. R22 stated staff were aware of her preference and had shaved chin hairs in the past.<br><br>During an observation on 5/11/21, at 2:50 p.m. R22 was in a recliner in her room, and was again observed to have multiple long, white hairs on her chin.<br><br>During an interview on 5/11/21, at 3:00 p.m. nursing assistant (NA)-A stated shaving was completed during morning cares. NA-A stated when providing morning cares if facial hair is noted, an offer to remove is made at that time. NA-A stated she had assisted R22 with morning cares.<br><br>During a subsequent observation at 3:13 p.m. NA-A confirmed R22 had visibly long chin hairs. R22 agreed to have the chin hairs shaved by NA-A at that time.<br><br>During an interview on 5/13/21, at 2:19 p.m. the director of nursing (DON) stated she expected staff to inform female residents of long facial hair and offer to assist them with shaving.<br><br>The facility's Quality of Life - Dignity Policy, revised 8/09, specified, "Residents shall be | F 677 | 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.<br><br>F677<br>-The process for satisfying this requirement has been reviewed and revised as needed, to ensure qualified GAF staff provide proper ADL care to dependent residents.<br>-Residents residing in this facility who are dependent upon qualified GAF staff to be shaved have the potential to be affected if this regulation is not met.<br>-R22 was immediately shaved.<br>-Necessary GAF staff have received education regarding shaving dependent residents when completing resident cares.<br>-Shaving education will be provided using Monarch Healthcare Management Policy and Procedure to any qualified GAF staff who provide ADL cares to dependent residents. | |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 677 | Continued From page 9<br>groomed as they wish to be groomed (hair styles, nails, facial hair, etc.)." | F 677 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain a clean and sanitary kitchen with regular cleaning when it was observed the floor, vent hood, griddle and toaster were not in clean, sanitary condition. This had the potential to affect all residents, staff and visitors who ate at the facility.<br><br>Findings include:<br><br>On 5/10/21, at 12:30 p.m. an initial tour of the kitchen was conducted with the facility's culinary | F 812 | 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 | 7/2/21 |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|

F 812

Continued From page 10

director. Inspection of the kitchen revealed food crumbs on the floor in the prep area of the kitchen with a layer of black grime under the prep tables. The flat top griddle had a thick layer of greasy dust covering the control panel, knobs and drip pan handle. A blackened substance covered approximately 90% of the griddle drip tray and approximately 40% of the burner drip tray. The vent hood filters were covered with approximately ½ inch layer of dust on the sides of each baffle plate, and a dark brown layer of grease covered the inside perimeter of the canopy hood. The three hanging light bulbs over the range were covered with a layer of grease and dust. The toaster tray was approximately 75% covered with burned on crumbs and the knob on the toaster was missing.

Observation on 5/11/21, at 2:32 p.m. food crumbs on the floor, black grime remained under each prep table, the griddle and burner drip trays remained dirty, and the control panel of the griddle still had grease build up. The dust from the vent hood filters were cleaned, but the inside perimeter of the canopy hood was still dirty. The three light bulbs over the range were still dirty. The toaster tray was still covered with crumbs and the toaster knob was still missing.

Observation on 5/12/21, at 8:17 a.m. food crumbs on the floor, black grime remained under each prep table, the griddle and burner drip trays remained dirty, and the control panel of the griddle still had grease build up. The inside perimeter of the canopy hood was still dirty. The three light bulbs over the range were still dirty. The toaster tray was still covered with crumbs and the toaster knob was still missing.

F 812

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.

F812
-The process for satisfying this requirement has been reviewed and revised as needed, to ensure food is prepared and served in a clean and sanitary environment.
-All Residents, Staff, and/or Visitors who eat at the facility have the potential to be affected if this regulation is not met.
-All identified areas have been cleaned and sanitized.
-Necessary GAF staff have received training utilizing Monarch Healthcare Management policy and procedure on cleaning and disinfection of environmental surfaces, along with appropriate service intervals, and/or to clean when visibly soiled.
-Audits will be completed five (5) 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

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 812 | Continued From page 11<br>During an interview on 5/12/21, at 8:35 a.m. culinary services aide (DA-A) stated cleaning was completed per the posted Daily Cleaning List and Weekly Cook Task documents and the range and oven were cleaned weekly. DA-A agreed that the griddle control panel, griddle drip pan and burner drip pan were dirty and not cleaned for over a week, saying, "Oh, that hasn't been done." DA-A further stated the toaster knob was missing for a while and a work order was not submitted for the toaster knob. In addition, DA-A stated the cleaning schedule was not followed and staff did not document completed cleaning tasks.<br><br>Observation on 5/13/21, at 9:25 a.m. food crumbs on the floor and black grime remained under each prep table.<br><br>During an interview on 5/13/21, at 9:32 a.m. assistant culinary director (ACD) stated there was not a cleaning log for tracking cleaning of the kitchen and equipment, stating, "We did it on good faith". The ACD further stated the floors were mopped at the end of each day, and a vendor was contracted to wax the floors twice a year at which time the vendor moved and cleaned under all equipment, but the vendor had not waxed the floor during the pandemic. In addition, the ACD stated, except for Ecolab for the dishwasher and the floor wax vendor, all kitchen cleaning and maintenance were managed by the facility, and staff were expected to report any issues to maintenance for repair.<br><br>Review of Daily Cleaning List indicated the flat top griddle and toaster were cleaned daily. However, the floor was not listed on the Daily Cleaning List. | F 812 | will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.<br>-Culinary Services Director or designee is responsible party.<br>-Corrective action will be completed by 7/02/2021. | |

| 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 05/13/2021 |

| 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 |
|---|---|---|---|---|
| F 812 | Continued From page 12<br>Review of the Weekly Cook Task indicated the hoods, range and oven were cleaned every Saturday.<br><br>The facility's Cleaning and Disinfection Procedures dated 9/12, indicated staff would follow general sanitation procedures. Procedures were listed for food preparation equipment, counter tops, appliances, coffee and milk machines, sinks and faucets, chairs and tables, and tile floors. Procedures for managing cleaning equipment and waste disposal were included. However, cleaning and disinfection of the vent hoods, refrigerators, freezers, range and ovens were not listed on the kitchen cleaning and disinfection procedure document. | F 812 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **05/12/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Federal Recertification Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Gardens at Foley, Building 01 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.<br><br>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.<br><br>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.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/11/2021 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **05/12/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>The facility was inspected as 1 building:<br>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 | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | 05/12/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>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 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).<br><br>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.<br><br>The facility has a licensed capacity of 78 beds and had a census of 69 at the time of the survey.<br><br>The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 271<br>SS=D | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.<br>18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide a hard-packed surface all-weather surface from an exit discharge to the public way as stated in the Life Safety Code | K 271 | 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 | 7/2/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **05/12/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| K 271 | Continued From page 3<br>(NFPA 101) 2012 edition sections 19.2.7, 7.7.1, 7.10.1 This deficient practice could restrict the exiting during an emergency and affect 16 of the 78 residents and an undetermined amount of staff and visitors.<br><br>Findings Include:<br><br>On the facility tour between 11:30 AM and 3:30 PM on 05/12/2021, observations revealed the exit discharge on the 300 wing did not have a hard packed path to the public way.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 271 | 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.<br><br>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.<br><br>K271<br>-Having a hard-packed, all-weather surface was identified as an area for improvement when upon observation, there was no such surface leading to a public way from the 300 wing emergency exit.<br>-All residents and occupants within the facility could potentially be affected if this requirement is not met.<br>-Monarch Healthcare Management, Maintenance Supervisor, and Administrator have been re-educated to the requirement and the identified area.<br>-Professional services are required to | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245325 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ____________ | **05/12/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT FOLEY LLC** | **253 PINE STREET**<br>**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 |
|---|---|---|---|---|
| K 271 | Continued From page 4 | K 271 | install an all-weather path to a public way. Appointments to obtain professional quotes / bids for service and permits have been scheduled.<br>-Completion of work is pending availability of professional services.<br>- Upon installation and completion of this project, audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately.<br>-Maintenance Director or designee is responsible party.<br>-Goal of corrective action to be completed by 7/2/2021, however, this is to be determined by availability of professional services. | |