Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

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

RE: CCN: 245325
Cycle Start Date: April 16, 2024

Dear Administrator:

On April 16, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), whereby corrections were required.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 16, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

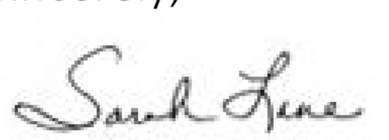
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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.

Feel free to contact me if you have questions.

Sincerely,



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

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 04/16/2024

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
F 000	INITIAL COMMENTS On 4/15/24, through 4/16/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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: H53253108C (MN00102387); H53253202C (MN00099382) with a deficiency cited at F689 at PAST NON-COMPLIANCE; H53253210C (MN00102386); H53253211C (MN00102258). In addition, as a result of the investigation, a deficiency was cited at F732. 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 that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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

Electronically Signed | 04/26/2024

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 689	Continued From page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow a care planned intervention to reduce the risk of falls for 1 of 4 residents (R4) reviewed for falls. This resulted in actual harm for R4 when he fell and sustained a thoracic fracture. R4 required subsequent hospitalization, where he expired. The facility implemented corrective action so the deficient practice was issued at past non-compliance. The past non-compliance began on 12/19/23, when R4 fell and sustained a fracture after staff failed to follow a care planned intervention. The facility implemented corrective action on 12/26/23, prior to the start of the abbreviated survey, and was issued as past non-compliance. Findings include: A Facility Reported Incident (FRI) report, submitted to the State Agency (SA) on 12/20/23 at 1:33 a.m., identified R4 fell at 3:25 p.m. after he self-transferred. R4 stated he gathered items in preparation for a shower, and when he went to grab the door handle, he missed and fell to the floor. He initially denied pain and requested the shower; however, subsequently reported increased lower back pain and was transported to the emergency department (ED). ED assessments and testing identified R4 sustained a T11 (thoracic 11th vertebrae) endplate fracture	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 with some dorsal displacement of the dominant fracture fragment. In addition, R4 required supplemental oxygen and was found to have elevated complete blood count (CBC) reading(s). The report identified R4's careplan directed staff to offer assist with setting out clothing for his evening shower. Nursing assistant (NA)-A was placed on administrative leave pending the investigation. R4's annual Minimum Data Set (MDS), dated 11/9/23, identified R4 was cognitively intact. He was diagnosed with debility, cardiorespiratory conditions, heart failure, anemia, and arthritis. R4 was free of falls over the prior three months. R4's Risk for falls care plan, revised on 11/24/23, identified R4 demonstrated "Gait/balance problems, weakness, refusal to wait for assistance, self-transferring at times, refusal to lift PWC (power wheelchair) footrests prior to transfers for safety as directed by therapy." The goal was for R4 to be free of serious fall related injury. A fall intervention, dated 5/27/20, directed NA to offer R4 assistance with setting out his clothing in preparation for his shower. A PointClickCare (PCC) POC (point of care) triggered task report for R4 identified the task, "Offer to assist me to set out my clothes for my shower (fall 5/26/20)," was triggered for the day NA to complete. The report indicated this task pushed to the Kardex's (NA care plan) safety category. A POC documentation report for R4 identified NA-A documented on 12/19/24, at 1:59 p.m., she offered R4 assistance to set out his cloths for his shower.	F 689		

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F 689	Continued From page 3 A progress note, dated 12/19/23 at 4:06 p.m., identified a NA went into R4's room to update him on the timeframe for his shower and found him on the floor. Vitals were taken and he was assisted into his wheelchair with a mechanical lift. R4 reported he felt fine and denied pain. R4 was initially assessed, and during his shower, a reddened area was noted on his lower back which R4 felt was related to a new belt he wore when he fell. A subsequent progress note, dated 12/19/23 at 8:10 p.m., identified R4 complained of significant lower back pain and nausea after his HS (hour of sleep) medications were administered. His vitals were WNL (within normal limits), as was his ROM (range of motion). His pupils were PEARL (equal and reactive to light). He was unable to lay down due to the increased pain, which was an 8 to 9 on a 0 to 10 pain scale. The on-call medical doctor and registered nurse (RN) were updated and R4 was transported to the ED. A Facility Investigation, completed 12/22/23, identified with immediate assessment after the fall, R4 denied pain. He initially refused to be transported to the hospital and requested his shower as planned. During the shower skin assessment, a reddened area on his lower back was noted. [NA-A] was placed on administrative leave pending further investigation. The investigation described R4 as a strong-willed 95-year-old who frequently self-transferred without notifying staff and/or using his call light and was very particular about his day and the way things were completed, specifically related to his showers. R4 stated he attempted to independently find his own clothes to be dressed	F 689		

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F 689	Continued From page 4 in after his shower. He grabbed for the door handle, missed, and fell to the floor. According to staff, he regularly obtained his clothing independently per his preference and failed to utilize his call light or obtain staff assist. In review of his care plan, the intervention to offer him assist to set up his clothing was identified. A review of the completed documented tasks identified [NA-A] completed this task on 12/19/23 at 1:59 p.m.; however, [NA-A's] interview indicated she did not assist R4 as documented. Additional staff interviews suggested R4 preferred to pick out his own clothing and did this "for some time." Due to the investigation, the facility substantiated the fall likely led to the fracture with evidence that suggested staff had an opportunity to assist R4 with his cloths prior to the fall. In response, NA-A received corrective action and education and the remainder of the nursing staff were educated to ensure tasks assigned in PCC's POC were completed and that they referred to the plan of care or their supervisor for any resident specific questions. In addition, additional care plans for those who required assistance with clothing selection were reviewed and determined to in fact be completed. The facility determined there were no similar incidents in the past six months, or since the initial report was filed with the SA, and therefore, this incident was believed to be an isolated incident. R4's hospital Discharge Summary - Death report, dated 12/25/23, identified R4's discharge diagnoses included a closed superior endplate T11 compression fracture with ankylosing spondylitis (spine arthritis) "reportedly due to mechanical fall" and worsened acute hypoxic respiratory failure due to increased atelectasis and the need for an ART (respiratory trauma	F 689		

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F 689	Continued From page 5 event team response). Neurosurgery was consulted; however, he was felt too high risk for surgery given his age, underlying comorbidities, and worsened respiratory failure, and thus he was transitioned to comfort cares. R4 "progressively became very drowsy during the course of hospitalization and passed away" on 12/25/23 at 12:40 a.m. During an interview on 4/15/24 at 1:54 p.m., NA-B stated he was expected to follow the plan of care and to ensure his documentation was accurate. He vaguely remembered R4; however, was typically not on R4's unit. He expressed R4 required setup assist and he preferred a particular aide to assist with showers. He indicated R4 fell and confirmed education that was provided to him shortly after was related to the fall and ensuring the care plan was followed. When interviewed on 4/15/24 at 2:09 p.m., NA-C stated she was expected to follow the plan of care and to ensure her documentation was accurate to ensure residents remained safe. She identified R4 required assist of one for cares; however, he was stubborn and tended to do things on his own as he did not like to ask for help. Due to this, he needed "strong encouragement" to ask for assistance. She explained education was provided after R4's fall to ensure tasks were followed and charting reflected the care provided. During an interview on 4/16/24 at 12:51 p.m., NA-A stated she was expected to follow the plan of care and to ensure her documentation was accurate to ensure residents remained free of harm, such as injuries or falls. She explained she was not on duty when R4 fell and identified she	F 689		

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F 689	Continued From page 6 "charted incorrectly" as she documented a task she did not complete. NA-A identified she was educated in relation to the incorrect charting and charting expectations, along with the need to ensure she followed the plan of care. When interviewed on 4/16/23 at 1:23 p.m., the DON stated she expected care plans and NA group sheets to be followed and if information was found incorrect, the managers or herself was to be updated to decrease the risk of injury and/or death. She went over the investigation steps taken after R4's fall which included NA-A's disciplinary action and staff education. She identified due to the investigation; it was identified NA-A failed to follow the plan of care. She denied related concerns since. On 4/16/24, during the DON interview, R4's facility fall investigation file was reviewed and contained the following: -A comprehensive fall investigation with summary of events, interviews, resident assessment, description of immediate resident protections, notifications, causal and/or contributing factors, and an overall detailed summary. -multiple staff interviews. -Notice of Suspension Pending Investigation, dated 12/20/23, for NA-A. -a Record of Verbal Counseling, dated 12/21/23, for NA-A with expectations going forward related to tasks and documentation. -a Care Planning policy signed by NA-A. -a staff list that identified those educated on 12/26/23, along with additional staff signed Care Planning and Task Education. -emailed communications with the medical provider and medical director.	F 689		

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F 689	Continued From page 7 The deficient practice was corrected on 12/26/23, after the facility implemented a plan that included the following actions: R4 was immediately assessed and fall protocols were followed. Upon R4's change in pain and mobility status, R4 was transferred to the ED. Facility investigation was coordinated with interviews of staff and R4, along with care plan review. NA-A was placed on administrative leave and provided verbal coaching and education after it was determined she failed to follow R4's plan of care. As of 12/26/23, most nursing staff were provided education related to the deficient practice and those who worked after were provided education upon their next shift. The facility was free of additional falls after 12/19/23 related to failure to follow plan of care. The corrective actions were verified through documentation review and staff interviews. A Care Planning policy, dated 1/6/22, identified each resident was to have a person-centered care plan to meet their individual medical, physical, psychosocial, and functional needs. The policy directed the care plan was to be utilized by staff for the purposes of providing care or services to the resident. The care plan was to be modified and updated as the condition and care needs of the resident changed.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		5/3/24

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F 732	Continued From page 8 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required nursing staff data was posted daily before each shift. This had potential to affect all 74 residents, staff, and visitors who could wish to review this information.	F 732	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 Administrator or any employees, agents or other	

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F 732	Continued From page 9 Findings include: During observation on 4/15/24 at 12:13 p.m., a nursing staff data posting was in a plastic holder on the wall between the reception desk and the dining room. The posting was labeled Daily Headcount, was dated 4/11/24, and printed off at 8:23 a.m. by scheduling coordinator (SC). On 4/15/24, at 12:14 p.m., the regional director of operations (RDO) and the administrator were located by the receptionist desk. The RDO verified the posting's location and identified date. He indicated SC was out ill that day. The administrator explained nursing staff "back[ed] [SC] up" when SC was out of the building. During an interview on 4/15/24, at 12:18 p.m., the director of nursing (DON) stated she expected the posting to be posted daily. She identified SC was responsible for the posting and expected the posting to be filled out in preparation for the next day, prior to the end of SC's shift. In addition, she expected SC prepared the weekend postings for the weekend night staff, who then were expected to post and make corrections as needed (i.e., calls ins, admissions, etc.). The DON denied audits were completed to ensure compliance with the posting and identified she was unsure what the process was when SC called in sick. After she was shown a copy of the observed posting, she stated, "So obviously it is a little late. I will have to find out where our system broke down." During observation on 4/15/24, at 1:15 p.m. and 5:00 p.m., the posting's plastic holder was empty. During observation on 4/16/24, at 9:13 a.m., a piece of paper, labeled Monday, April 15th, was in	F 732	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. F732 s/s C • The process for satisfying this requirement has been reviewed and revised as needed, to ensure the actual hours and number of each direct nursing staff are posted per each shift. • This had the potential to affect all residents, staff, and visitors who wished to view the information. • The actual hours and number of each member of staff have been updated as necessary and posted in a conspicuous location for public viewing. • All necessary GAF nursing staff received education regarding the requirement to post nursing staff information. • Audits will be completed to ensure	

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	245325	A. BUILDING _____ B. WING _____	C 04/16/2024

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F 732	Continued From page 10 the plastic staff data posting sleeve, and identified staff data. This paper was not like the previously observed 4/11/24 Daily Headcount. Less than one minute later, SC was observed by her office. When interviewed on 4/16/24, at 10:01 a.m., SC indicated she started her position in September and officially took over the staff posting on 10/23/23. She explained, one of the first things she did upon arrival to work at 8:00 a.m., when she performed her scheduler duties, was she ran a staff posting report in the "UKG" electronic system and posted it. She identified the only staff that she was aware of that could access this part of the UKG software was the DON and the administrator, and potentially human resources. She lacked knowledge related to the process of the posting when she was not in the building, which included weekends. In addition, she explained there were days when she was required to work direct care and thus the posting was not posted on those days, as she went straight to the floor. SC was unaware of the posting requirements and explained that during her position orientation she was only instructed it needed to be posted but not why. SC denied she posted the posting that morning as she "got sidetracked." She ran a Daily Headcount report for 4/16/24 at 10:04 a.m. The Daily Headcounts from 10/23/23 to current were reviewed with SC in which she confirmed the saved Daily Headcounts reviewed were the postings that she posted. If the postings were not present, they were not posted. The saved Daily Headcount postings from 10/23/23, through 4/15/24 were requested and identified the following: -81 days out of an expected 176 days were	F 732	compliance. 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. • Compliance will be achieved on or before 5/03/2024.	

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F 732	Continued From page 11 provided. -all postings were printed by SC. -posting time stamps ranged from 7:33 a.m. to 8:57 a.m., with one posting at 12:54 p.m. Most of the posting were time stamped around the 8:00 a.m. hour timeframe (approximately two hours past the start of the day shift). -October 2023 postings lacked the dates of 10/28/23 and 10/29/23 (two days). -November 2023 postings lacked the dates of 11/1/23, 11/2/23, 11/4/23 - 11/7/23, 11/10/23 - 11/12/23, 11/17/23 - 11/19/23, 11/23/23 - 11/26/23 (16 days). -December 2023 postings lacked the dates of 12/2/23, 12/3/23, 12/6/23, 12/7/23,12/9/23 - 12/11/23, 12/16/23, 12/17/23, 12/19/23, 12/23/23 - 12/25/23, 12/30/23, 12/31/23 (15 days). -January 2024 postings lacked the dates of 1/1/24, 1/2/24, 1/6/24, 1/7/24, 1/10/24, 1/12/24 - 1/14/24, 1/16/24, 1/18/24, 1/20/24, 1/21/24, 1/23/24, 1/27/24, 1/28/24, 1/31/24 (16 days). -February 2024 postings lacked the dates of 2/1/24, 2/3/24 - 2/5/24, 2/7/24, 2/9/24 - 2/12/24, 2/17/24, 2/18/24, 2/20/24, 2/21/24, 2/24/24 - 2/27/24 (17 days). -March 2024 postings lacked the dates of 3/2/24, 3/3/24, 3/7/24, 3/9/24, 3/10/24,3/16/24, 3/17/24, 3/19/24, 3/20/24, 3/23/24 - 3/31/24 (18 days). -April 2024 postings lacked the dates of 4/4/24 - 4/10/24, 4/12/24 - 4/15/24 (11 days). A Nursing Hours Posting policy, dated 10/2/22, directed the facility posted nursing staffing data daily at the beginning of each shift.	F 732		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2024

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

Re: Event ID: CTSG11

Dear Administrator:

The above facility survey was completed on April 16, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

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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 4/15/24, through 4/16/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure at the time of the survey. The following complaints were reviewed.	2 000		

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2 000	Continued From page 1 H53253108C (MN00102387), H53253202C (MN00099382), H53253210C (MN00102386), H53253211C (MN00102258) with no licensing order issued. 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		