



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 4, 2026

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

RE: CCN: 245325

Cycle Start Date: August 21, 2026

Dear Administrator:

On August 21, 2026, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified

as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 21, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 21, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

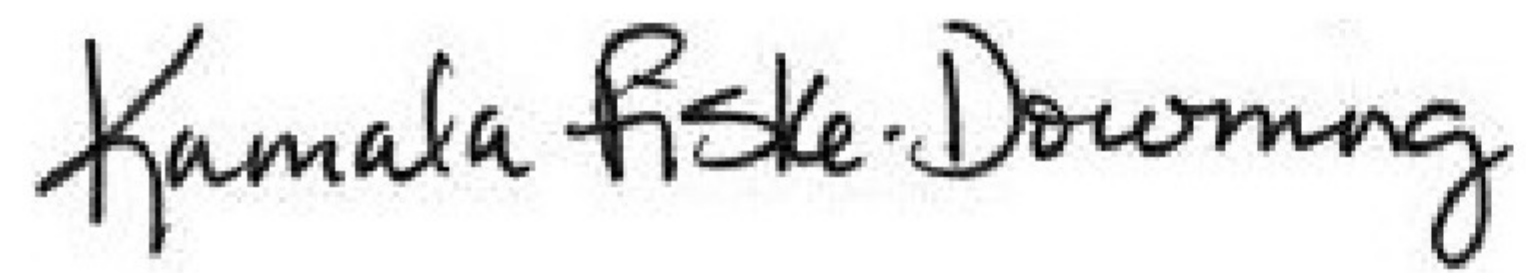
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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September 4, 2026

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

Re: Event ID: 342103-H1

Dear Administrator:

The above facility survey was completed on August 21, 2026 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245325		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT FOLEY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 253 PINE STREET , FOLEY, Minnesota, 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
F0000	INITIAL COMMENTS On 8/20/26 through 8/21/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed. H53253801C (3167145) H53253565C (3135070, 3120894) As a result of the survey a deficiency was issued at F689. 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.			F0000			09/18/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:			F0689	The process for ensuring a thorough elopement assessment has been performed upon resident admission to the facility has been reviewed and revised as needed to ensure that resident(s) are not leaving the facility without staff knowledge. R4 had an elopement assessment completed on 7/21/26. The resident scored a 5 at that time, identifying that she was an elopement risk, and a wander guard was placed at that time to safeguard residents' safety. No harm or injury resulted in residents being outside of facility grounds without staffs' knowledge. Residents that have been admitted to the Gardens at		09/18/2026

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 reverse for further 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.

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

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F0689 SS = D	Continued from page 1 Based on interview and document review the facility failed to perform a thorough elopement assessment upon admission for 1 of 1 resident (R4) resulting in R4 leaving the facility without staff knowledge. Findings include: R4’s Admission Record indicated she admitted to the facility 7/14/26. R1’s diagnoses included dementia with moderate agitation, depression and transient ischemic attack (a temporary blockage of blood flow to part of the brain that causes stroke-like symptoms without leaving permanent damage). R4’s Elopement Risk Evaluation dated 7/14/26, indicated she was not at risk for elopement. R4’s admission Minimum Data Set (MDS) dated 7/20/26, identified severe cognitive impairment and indicated wandering behaviors occurred one to three days during the assessment period. The MDS indicated R4 transferred and ambulated independently. R4’s 48 Hour Care Plan indicated alteration in psychosocial well-being and directed staff to monitor safety concerns as needed, i.e.: elopement. R4’s care plan dated 7/14/26, identified an alteration in cognition and an alteration in mood and behavior. The care plan goal indicated R1 would respond to interventions by staff to calm and redirect her. Updated 7/23/26, R4 exhibited wandering behavior related to cognitive impairment that placed her at risk for injury, disorientation and entering unsafe areas. R4’s Progress Notes indicated the following: 7/15/26- Provider encounter note: Diagnosis included Dementia, severe with agitation. R4 admitted from another long-term care facility where the goal was to regain functional independence. The recommendation upon discharge from the facility was long-term memory care with 24/7 supervision. Brief interview for mental status score was 6/15, which indicated severe cognitive impairment. 7/19/26- R4 was wandering around the unit asking what she was doing there and stated she would like to go home. Staff offered activity, snacks and re-direction, which was not effective. Family members called and spent time with R4. R4 in bed at time of note.			F0689	Continued from page 1 Foley (GAF) within the last 60 days have the ability to be affected should this assessment not be thoroughly completed. All residents admitted to the facility within the last 90 days have been reviewed, and a new elopement assessment has been completed. Any necessary wander guard placement, based on elopement scoring, has been implemented. All necessary GAF staff have received education regarding facilities policy and procedure titled Elopement Policy, including but not limited to family involvement in the assessment process. Audits will be completed to ensure that the completion of a thorough elopement assessment upon resident admission to the facility has been completed and documented for two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or Designee is the responsible party. Corrective Action will be completed on or before 9/18/26.		09/18/2026

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F0689 SS = D	Continued from page 2 7/20/26- 7:53 p.m., R4’s family member was alerted R4 left the building to go for a walk without informing staff. R4 had not signed out and was educated on the importance of signing out when leaving. R4 was located by the apartment building across the street from the facility. Police were contacted and assisted. R4 stated she wanted to walk to her farm. Wander guard was placed at that time. Untitled facility document dated 7/20/26, indicated staff member last saw R4 at approximately 6:00 p.m. R4 had been in the day room and asked who was in charge so she could talk to them. R4 was re-directed to a recliner to sit. Staff left the area. When staff returned, R4 was up and “looking upset.” Staff went to assist another resident and upon return was unable to find R4. R4 was located in less than 30 minutes. Untitled facility document dated 7/20/26, indicated staff reported R4 went out the front door because she wanted to go home. Earlier staff had been trying to re-direct R4 due to exit seeking. R4 was located across the street. When asked, R4 said she wanted to go home but someone was chasing her so she hid in the bushes. R4’s Community Mobility Assessment Form dated 7/21/26, indicated R4 had increased difficulty with shortness of breath and decreased balance. R4 did not have access to a phone or emergency call when outdoors. R4 was unable to orient to place or location outdoors, lacked capacity or insight into risk factors outdoors, did not find way back to staff and was unable to remember directions when navigating an unfamiliar area. R4 did not identify safety hazards when crossing the street. R4 was not safe to independently ambulate outdoors. During interview on 8/21/26 at 11:15 a.m., registered nurse (RN)-A stated the facility knew very little about R4 prior to admission. "When [R4] arrived at the facility she did not have orders. No report was given to us from the nurse at the previous facility." RN-A stated assessments were completed upon admission. Within two days an initial (48 hour) care plan was developed. RN-A said R4 was not at risk for elopement when she admitted. The concern for elopement was identified on the day she eloped. RN-A said she had not been aware R4 had asked to go home on 7/19/26 and said “that was a Sunday so I didn’t know about that.” RN-A said she reviewed progress notes on Monday, no new interventions were implemented for R4 in response			F0689			09/18/2026

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F0689 SS = D	Continued from page 3 to her request to go home or change in behavior over the weekend. RN-A said she had never asked about elopement attempts at the previous facility and did not call for a nurse to nurse report, “it slipped through the cracks.” RN-A stated she had not been aware of the recommendations for 24/7 supervision and memory care. When R4 left, RN-a had only heard that staff had to call the police and R4 was found in the bushes across the street. During interview on 8/21/26 at 11:33 a.m., the director of nursing (DON) stated she would have expected staff to gather information to complete an accurate elopement risk assessment. Typically, upon admission the nurses got a report from the nurse at the prior facility. That should have happened prior to completion of R4's assessments. The DON indicated she had been out during the time of R4’s elopement and not part of the admission or assessments. During interview on 8/21/26 at 11:52 a.m., the assistant DON (ADON) stated she was not part of R4’s admission but said she remembered they wanted to place her in the secured unit from the start. ADON stated she read R4 was agitated in her previous facility and wanted to go home. The ADON said the secured unit was been full when R4 admitted. The ADON stated the facility could have placed a wander guard on R4 when she admitted. During interview on 8/21/26 at 11:59 a.m., RN-C stated the evening R4 eloped, she received a phone call from staff around 6:30 p.m., so RN-C went to the facility. RN-C said she had stopped a few places on the way to look for R4 and when she pulled into the parking lot the police and a nursing assistant were walking with R4 into the building. RN-C said a wander guard was placed on R4 after she returned to the facility. Facility Elopement Policy dated 11/2025, indicated upon admission, each resident is assessed to establish elopement risk. The family may be interviewed for resident's previous history of elopement and responses recorded in the medical record.			F0689			09/18/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/20/26 through 8/21/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H53253801C (3167145) H53253565C (3135070, 3120894)		20000			09/18/2026	

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 As a result of the survey a licensing order was issued at 0830. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.			20000			09/18/2026