Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2024

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 8, 2024

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

Re: Reinspection Results
Event ID: Z2O312

Dear Administrator:

On October 7, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 13, 2024

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

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

Dear Administrator:

On August 22, 2024, we informed you that we may impose enforcement remedies.

On August 29, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 8, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 8, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Gardens At Foley Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 February 8, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 08/29/2024

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 8/28/24 through 8/29/24, a standard abbreviated survey was conducted at your facility. 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: H53256817C (MN00105733) H53257231C (MN00105933) Deficiencies were issued at F684 and F880. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review,	F 684	F684 s/s D	9/27/24

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

Electronically Signed | 09/23/2024

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

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F 684	Continued From page 1 the facility failed to complete post-fall vital signs and neurological assessments for 3 of 3 (R1, R2, R3) residents reviewed for post-fall assessment and monitoring. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/1/24 indicated R1 had diagnoses of dementia and heart failure. R1's MDS assessment indicated he had moderate cognitive impairment, and required assistance with transfers and personal cares. R1's care plan dated 5/13/24 indicated he was at risk for falls. On 8/11/24 at 2:40 p.m., a progress note indicated R1 was found on the floor by the nursing assistant. R1 was holding his head, and his oxygen saturation rate was initially low at 64%, but then rose to 84% (normal is 90% andabove). The note indicated a skin assessment was conducted, the provider was contacted, family was present and R1 was sent to the emergency department (ED). On 8/13/24 at 9:23 a.m. a progress note written by registered nurse (RN)-C summarized the incident. R1 was noted to be minimally responsive with sternal rub. Vital signs were taken and were within normal limits with the exception of oxygen saturation, which was "in the lower 80's." R1 was sent to the ED to be evaluated and returned without any concerns. R1 had a skin tear and a large bruise, and denied pain. The incident was reviewed with the interdisciplinary team (IDT).	F 684	- The process for satisfying this requirement has been reviewed and revised as needed, to ensure that post-fall vital signs and neurological assessments are completed appropriately for residents who fall. - All current, alike residents, who have been identified have the potential to be affected if this requirement is not met. - R1 and R2 were evaluated in the emergency department and R3 was evaluated by staff. No health risks were identified. - Immediate education was initiated and completed on 8/29/24, during post certification survey education for all GAF staff. -Alike residents were reviewed and evaluated as necessary. - Appropriate GAF staff have been re-educated to this requirement utilizing Monarch Healthcare Management policy and procedure. - Education and procedures have been updated as necessary to ensure compliance by external agency staff. - To monitor performance and ensure sustainability, audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 9/27/2024.	

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F 684	Continued From page 2 On 8/13/24 at 9:23 a.m. a progress note referenced the risk management report, indicating R1 was found on the floor on his right lateral side, and was holding his head off the floor. The nurse provided a pillow to R1. Initial oxygen saturation reading was 64%, followed by an 84% reading, with the rest of the vitals within normal range. Ten minutes later, R1's family members were present. Provider and on-call physician were notified of the fall. R1 refused to go to the ED for further evaluation, but his pain increased to 8 out of 10, and R1 agreed to go to the ED after a few hours. R1's medical record lacked frequent post-fall neurological assessments from the time of the fall at on 8/11/24 at 2:40 p.m. to the time R1 was sent to the hospital. An emergency department note indicated R1 arrived at the hospital at 5:18 p.m. on 8/11/24. On 8/28/24 at 11:48 a.m., the assistant director of nursing (ADON) stated post-fall neurological assessments were a part of the facility's protocol when a resident fell and hit their head, or had an unwitnessed fall. On 8/28/24 at 1:57 p.m. RN-D stated the nurse should complete post-fall neurological assessments after a fall with a head strike or an unwitnessed fall. On 8/28/24 at 2:28 p.m., registered nurse (RN)-B stated she was working when R1 fell. She did an initial set of vital signs. She did not have the form to complete frequent neurological assessments available. She checked on R1 every 15 minutes for the first hour, but did not document it.	F 684		

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F 684	Continued From page 3 R2's admission MDS dated 8/8/24 indicated R2 had diagnoses of unsteadiness of his feet and pain. R2's MDS indicated R2 had a history of falls. R2's care plan dated 8/6/24 indicated R2 was at risk for falls. On 8/20/24 at 4:42 p.m. a progress note indicated per risk management note: R2 was found on the floor in his room at 2:00 p.m. by nursing assistant (NA) with his forehead on the floor, with minor bleeding. Vital signs noted. R2 refused to go to the hospital for evaluation. R2's family member came around midnight. Shortly after the family member left, R2's condition changed. Confusion and an elevation blood pressure were noted and R2 was sent to the ED. On 8/20/24 at 4:55 p.m., a progress note indicated R2 reported he was in his wheelchair and had dropped an item on the floor, and was attempting to reach the item when he fell. While in the ED, he was diagnosed with COVID. R2's chart lacked frequent post-fall neurological assessments for the 12 hours prior to going to the emergency room for evaluation. R2 fell at 2:00 p.m on 8/20/24 and 911 was called at 2:30 a.m. on 8/21/24 due to his change of condition. On 8/29/24 at 10:05 a.m., RN-C stated the nurse should have completed frequent post-fall neurological assessments per facility protocol. On 8/29/24 at 10:45 a.m., RN-E stated nurses should follow the facility fall protocol, treating any unwitnessed fall as a head strike, and complete	F 684		

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F 684	Continued From page 4 neurological assessments. If the neurological assessment form were missing from the packet, the nurse should ask the nurse manger on-call where to find the form. On 8/29/24 at 11:33 a.m., RN-B state she was working when R2 fell. R2 was found with some minor bleeding to his head. She had been taking his vitals "consistently," but did "verbally" because she could not locate the neurological assessment form. RN-B stated she did not document her assessments for R2, but had frequent interactions with him. R3's annual MDS dated 7/18/24, indicated R3 had diagnoses of dementia and history of falls. R3's MDS indicated he had severe cognitive impairment and required supervision with all personal cares and transfers. R3's care plan dated 7/12/23 indicated R3 was a fall risk. On 8/28/24 at 7:55 a.m., a progress note indicated R3 was found on the floor, unable to recall how fall occurred, but thought to be self-transferring. Neuros were started and were within normal limits. On 8/28/24 at 2:58 p.m., a progress note indicated R3 was being monitored for behaviors. Note lacked post fall assessment details. An Incident Review form dated 8/28/24 at 11:00 a.m., indicated R3 was found on the floor. The note indicated neuros were started, and family and physician were notified. An x-ray was ordered.	F 684		

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F 684	Continued From page 5 On 8/29/24 at 12:21 p.m., licensed practical nurse (LPN)-A stated she was working when R3 fell on 8/28/24. She had completed his post fall assessments, from the time of R3's fall at 7:55 a.m. through 1:45 p.m on 8/28/24, per the protocol on the designated facility form, but she was unable to locate the form in R3's medical record. On 8/29/24 at 12:21 p.m., LPN-A stated she was working with R3 immediately after his fall. She completed his initial frequent vital signs and neurological assessments, but the form was missing. If she could not locate a document, she would ask a clinical manager where to find one and still complete the necessary actions. LPN-A stated she would just write them on a sheet of paper if the form were missing. A facility document Neurological Procedure, dated 6/21 directed neurological assessments are indicated: a. Upon physician order. b. Following an unwitnessed fall. c. Following a fall or other accident/injury involving head trauma; or d. When indicated by resident's by resident's condition. When assessing neurological status, always include frequent vital signs. Particular attention should by paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP). e. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. Check vital signs and do neuro checks immediately and with the following frequency:	F 684		

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F 684	Continued From page 6 Every 15 minutes x 4, Every 30 minutes, x 2, Every 1 hours, x 4, then every 4 hours for a total of 24 hours. Documentation: The following information should be recorded on the neurological flow sheet and placed in the resident's medical record:	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		9/27/24

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

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F 880	Continued From page 7 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility	F 880	F880 s/s D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 8 failed to follow the Centers for Disease Control (CDC), Infection Control Guidance: SARS-CoV-2 (severe acute respiratory syndrome coronavirus 19) dated 6/24/24, which directed the facility to implement source control measures to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. On 8/28/24 at 9:50 a.m. a sign on the front door of the facility indicated the facility had a current COVID outbreak. On 8/28/24 at 9:55 a.m., the director of nursing (DON) The DON stated the census of the building was 68 and confirmed there was a current COVID outbreak in the facility. On 8/28/24 at 3:11 p.m., therapeutic recreation aide (TRA)-A was observed in the dining room in close proximity to three residents while they were all seated at a table, approximately 2 feet apart. TRA-A's mask was positioned under his chin, not covering his mouth or nose. On 8/28/24 at 3:13 p.m., registered nurse (RN)-A was observed standing at the medication cart in the hall of the 400 unit, with his surgical mask under his chin. The mask was not covering his mouth or nose. RN-A was observed pulling the mask up to the correct position to cover his mouth and nose. On 8/28/24 at 3:16 p.m., RN-A was observed with his mask under his chin, speaking to a resident who was within approximately three feet of RN-A at the medication cart on the 400 unit. The resident was also not wearing a mask.	F 880	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure GAF staff appropriately wear masks that cover both their nose and mouth. -Residents residing on the 400 unit where RN-A was working, along with residents working with TRA-A had the potential to be affected. -RN-A and TRA-A were immediately educated in accordance with CMS standards utilizing Monarch Healthcare Management policy and procedures. - In accordance with CMS standards, Monarch Healthcare Management policy and procedure was utilized to immediate educate GAF staff during post certification survey education on 8/29/24 - To monitor performance and ensure sustainability, audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 9/27/2024.	

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F 880	Continued From page 9 On 8/28/24 at 3:18 p.m., RN-A stated the goal of wearing the mask was to minimize spreading COVID. RN-A stated wearing the mask under his chin was not the appropriate method to prevent the spread of infection. On 8/28/24 at 3:20 p.m., TRA-A stated he was aware the proper way to wear a mask way above the nose and over the mouth. On 8/28/24 at 3:38 p.m., the DON stated indicated 7 residents in the building currently had COVID. She stated the residents with COVID were on the 200, 400, and 500 units. The DON stated staff education was conduction through daily huddles at shift changes, on facility bulletin boards, and on residents' doors. The DON stated the expectation was that staff were to wear surgical masks at all times in common areas of the buildings. The DON stated it was unacceptable to wear the surgical masks under the chin. On 8/29/24 at 8:51 a.m., the infection prevention nurse (IPN) stated staff are expected to wear a mask in common areas while the facility is in outbreak status and staff are expected to wear masks properly, covering mouth and nose. On 8/29/24 at 1:57 p.m., the medical director stated surgical masks must be worn in common areas of the facility and worn properly to prevent the spread of COVID. The medical director stated the masks must be worn covering the mouth and nose. A facility document, COVID Policy, dated 3/7/24 directed this facility follows recommended standard and transmission-based precautions,	F 880		

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F 880	Continued From page 10 environmental cleaning, to prevent the transmission of COVID-19 within the facility. This policy is based on current CDC recommendations for infection prevention and control practices for COVID-19. While in the building, personnel are required to adhere to established infection prevention and control policies, including: appropriate use of PPE. Centers for Disease Control (CDC), Infection Control Guidance: SARS-CoV-2 (severe acute respiratory syndrome coronavirus 19), dated 6/24/24, directed the facility to implement source control measures to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: Z2O311

Dear Administrator:

The above facility was surveyed on August 28, 2024 through August 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	08/29/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/28/24 through 8/29/24, 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, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53256817C (MN00105733) H53257231C (MN00105933) A licensing order was issued at 4658.0800 Subp.1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to follow the Centers for Disease Control (CDC), Infection Control Guidance: SARS-CoV-2 (severe acute respiratory syndrome coronavirus 19) dated 6/24/24, which directed the facility to implement source control measures to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. On 8/28/24 at 9:50 a.m. a sign on the front door of the facility indicated the facility had a current COVID outbreak. On 8/28/24 at 9:55 a.m., the director of nursing (DON) The DON stated the census of the building was 68 and confirmed there was a current COVID outbreak in the facility.	21375	corrected	9/23/24

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21375	Continued From page 3 On 8/28/24 at 3:11 p.m., therapeutic recreation aide (TRA)-A was observed in the dining room in close proximity to three residents while they were all seated at a table, approximately 2 feet apart. TRA-A's mask was positioned under his chin, not covering his mouth or nose. On 8/28/24 at 3:13 p.m., registered nurse (RN)-A was observed standing at the medication cart in the hall of the 400 unit, with his surgical mask under his chin. The mask was not covering his mouth or nose. RN-A was observed pulling the mask up to the correct position to cover his mouth and nose. On 8/28/24 at 3:16 p.m., RN-A was observed with his mask under his chin, speaking to a resident who was within approximately three feet of RN-A at the medication cart on the 400 unit. The resident was also not wearing a mask. On 8/28/24 at 3:18 p.m., RN-A stated the goal of wearing the mask was to minimize spreading COVID. RN-A stated wearing the mask under his chin was not the appropriate method to prevent the spread of infection. On 8/28/24 at 3:20 p.m., TRA-A stated he was aware the proper way to wear a mask way above the nose and over the mouth. On 8/28/24 at 3:38 p.m., the DON stated indicated 7 residents in the building currently had COVID. She stated the residents with COVID were on the 200, 400, and 500 units. The DON stated staff education was conduction through daily huddles at shift changes, on facility bulletin boards, and on residents' doors. The DON stated the expectation was that staff were to wear surgical masks at all times in common areas of	21375		

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21375	Continued From page 4 the buildings. The DON stated it was unacceptable to wear the surgical masks under the chin. On 8/29/24 at 8:51 a.m., the infection prevention nurse (IPN) stated staff are expected to wear a mask in common areas while the facility is in outbreak status and staff are expected to wear masks properly, covering mouth and nose. On 8/29/24 at 1:57 p.m., the medical director stated surgical masks must be worn in common areas of the facility and worn properly to prevent the spread of COVID. The medical director stated the masks must be worn covering the mouth and nose. A facility document, COVID Policy, dated 3/7/24 directed this facility follows recommended standard and transmission-based precautions, environmental cleaning, to prevent the transmission of COVID-19 within the facility. This policy is based on current CDC recommendations for infection prevention and control practices for COVID-19. While in the building, personnel are required to adhere to established infection prevention and control policies, including: appropriate use of PPE. Centers for Disease Control (CDC), Infection Control Guidance: SARS-CoV-2 (severe acute respiratory syndrome coronavirus 19), dated 6/24/24, directed the facility to implement source control measures to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21375		

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21375	Continued From page 5 establish a system to track proper PPE use. The facility could conduct periodic audits of staff proper utilization of PPE. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance. TIME FOR CORRECTION: Twenty-one (21) days.	21375		