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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43080

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 [DATE], when R4 fell and sustained a fracture after staff failed to follow a care planned intervention. The facility implemented corrective action on [DATE], 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 [DATE] 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 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 [DATE], 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 [DATE], 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 [DATE], directed NA to offer R4 assistance with setting out his clothing in preparation for his shower.

(continued on next page)

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.

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

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NAME OF PROVIDER OR SUPPLIER The Gardens at Foley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 253 Pine Street Foley, MN 56329	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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 [DATE]), 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 [DATE], at 1:59 p.m., she offered R4 assistance to set out his cloths for his shower. A progress note, dated [DATE] 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 [DATE] 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 [DATE], 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 [AGE] 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 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 [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's hospital Discharge Summary - Death report, dated [DATE], 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 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 [DATE] at 12:40 a.m. During an interview on [DATE] 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 [DATE] 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 [DATE] 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 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 [DATE] 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 [DATE], 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 [DATE], for NA-A. -a Record of Verbal Counseling, dated [DATE], for NA-A with expectations going forward related to tasks and documentation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-a Care Planning policy signed by NA-A. -a staff list that identified those educated on [DATE], along with additional staff signed Care Planning and Task Education. -emailed communications with the medical provider and medical director. The deficient practice was corrected on [DATE], 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 [DATE], 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 [DATE] related to failure to follow plan of care. The corrective actions were verified through documentation review and staff interviews. A Care Planning policy, dated [DATE], 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.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43080 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. 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 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. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	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 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.