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	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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 Based on interview and documentation review, 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 [DATE] 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). 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Gardens at Foley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. R2's admission MDS dated [DATE] 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 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 [DATE], 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Gardens at Foley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. On 8/29/24 at 12:21 p.m., licensed practical nurse (LPN)-A stated she was working when R3 fell on [DATE]. 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: 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: The Gardens at Foley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 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. On 8/28/24 at 3:11 p.m., therapeutic recreation aide ([NAME])-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. [NAME]-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., [NAME]-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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Gardens at Foley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.