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	11/14/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and document review, the facility failed to ensure antibiotic was administered per physician orders for 1 of 1 resident (R1) reviewed for medication administration. Findings include: R1's Admission Record dated 10/24/24, indicated R1's primary diagnosis was Osteomyelitis. The Admission Record further indicated R1 had methicillin susceptible staphylococcus aureus infections (a type of staph that can be resistant to several antibiotics) as the cause of the diseases as his secondary diagnosis. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE] and had orthopedic condition, no memory loss or behaviors. The MDS further indicated R1 needed assistance with ADL's, had lower extremity weakness and used a wheelchair for mobility. R1 further received intravenous antibiotics. R1's Care Plan dated 10/26/24, indicated R1 had a peripherally inserted central catheter (PICC) line and was at risk for infections, had self care deficit related to infection and had risk for skin integrity. R1's Hospital Discharge Orders dated 10/24/24, indicated R1 was to receive sodium chloride 0.9% 250 milliliters (ml) with oxacillin (antibiotic) 2 gram 24 hour continuous. R1's Hospital Medication Administration Report dated 10/24/24, indicated while at the hospital the medication was started at 7:04 a.m. on 10/24/24, (the next dose would need to be started at 7:04 a.m. on 10/25/24). R1's Medication Administration Record (MAR) at the facility indicated on 10/25/24, R1 received his next IV sodium Chloride 0.9% 250 ml 2 gram 24 hour continuous at 12:19 p.m. (over 5 hours late). Review of R1's Progress Notes (PN) indicated on 10/26/24, at 4:26 p.m. writer entered room where family stated resident appeared to be increasingly confused. Writer completed assessment noted congestion to upper lungs and nonproductive cough. BP 157/75, pulse 121, respiratory rate 121, pulse 20, temperature 102.9. The indicated family wanted R1 sent in and primary care provider updated and orders received to send to hospital. (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 11/14/2024

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital History and Physical dated 10/26/24, indicated R1 was admitted with a fever. The H&P indicated R1 was previously hospitalized [DATE] to 10/24/24, secondary to persistent right hip tenderness, and right iliac bone Osteomyelitis and infections myositis (a disease that makes your immune system attack your muscles) and was discharged on oxacillin continuous infusion. The H&P indicated R1 was started on broad-spectrum antibiotics and was discharged back to the facility on [DATE]. A Medication Error Dispensing Error And Treatment Error Report indicated on 11/05/24, R1 was supposed to receive oxacillin 24 hour continuous and registered nurse (RN)-B (agency nurse) signed as given on 11/05/24. The report indicated the night shift nurse found at 3:00 a.m. on 11/06/24, the oxacillin had not been started on 11/05/24 and the antibiotic was missed for 12 hours. The report indicated the primary care provider was notified and the nurse was placed on due not return due to concerns with the medication error to follow up with further education. A facility PN dated 11/06/24, at 3:13 p.m. indicated it was reported by the night nurse that resident did not get his antibiotic noted at 3:00 a.m. due to have been changed at 3:00 p.m. last evening. The PN indicated the night nurse restarted the antibiotic and at 8:30 a.m. his legs were at least 3 plus pitting edema and that the left lower leg was and red and had some water blister on the lower leg, the skin was also very shinny. Resident did not complain of pain and the area was not warm to touch. Physician was called and stated to have the resident go to the emergency room to eval and treat. During interview on 11/13/24, at 2:20 p.m. director of nursing (DON) stated she was unaware R1 received his antibiotic 5 hours late on 10/26/24 and the nurses were supposed to look at the hospital MAR to see when the antibiotics were started at the hospital. The DON stated RN-B signed out she gave R1 his antibiotic on 11/05/24, at 3:00 p.m. and it was discovered on 11/06/24, at 3:00 a.m. the medication was not started. The DON stated RN-B was agency nurse and her first day at the facility, after they discovered her medication error they immediately called the agency and put her on a do not return and informed the agency she needs further training. The DON further stated it is the facility's expectation the nurses from the agency are competent with administering IV medications and if they are not they should inform the facility, in addition the DON stated that evening there was another nurse from their facility who was certified in administering IV medications if she had questions. The DON stated the medical director felt the medication error did not cause harm and did not feel it was the cause for R1's hospitalization s. In addition the DON stated R1 did not hold his bed so they were unable to find out any information from his hospitalization on [DATE]. When requested RN-B's phone number the DON stated since they placed her on due not return they would not be able to receive her phone number. Facility Policy Medication Procedure reviewed 1/2020, indicated for determining significance of a medication error: The relative significance of medication errors is a matter of professional judgment. Follow three general guidelines in determining whether a medication error is significant or not: Resident Condition - The resident ' s condition is an important factor to take into consideration. If the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident ' s condition requires rigid control, a single missed or wrong dose can be highly significant. Drug Category - If the medication is from a category that usually requires the resident to be titrated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This is especially important with a medication that has a Narrow Therapeutic Index (NTI). Frequency of Error - If an error is occurring repeatedly, there may be more reason to classify the error as significant. For example, if a resident ' s medication was omitted several times, it may be appropriate, depending on consideration of resident condition and medication category.