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	10/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to adequately assess, document, and provide appropriate staff and provider updates for treatment orders for 1 of 3 residents (R1), when R1 was found to have buttock redness during an initial skin assessment that did not dissipate with pressure reduction, or when an open area was observed by staff to R1's buttocks the following day. R1 admitted to the facility on [DATE] and discharged on 10/16/25.Findings include: A 10/8/25 hospital Oncology Note identified R1 had pain related to concurrent chemoradiation therapy and radiation dermatitis (Grade 1) to the inguinal (groin) area. R1's hospital Discharge summary, dated [DATE], identified R1's primary problem was vaginal pain. R1 was diagnosed with vulvar cancer and underwent chemotherapy, and radiation that started on 10/8/25. She was provided discharge orders for perineal care related to dryness, to help wick moisture away, and for discomfort to the groin/vulva area [related to effects of radiation]. Additionally, R1 was previously discharged from the hospital on [DATE] with a commuted fracture of the left humerus (shoulder) that brought about issues of self-care due to cast use. A review of R1's hospital notes lacked evidence to support buttock/coccyx skin impairments (i.e., redness/wounds/pressure ulcer(s) were identified during her hospital stay. R1's Admission/Initial Data Collection form, dated 10/10/25, completed by registered nurse (RN)-A, identified a Skin section that housed a subsection to document Incisions, Discoloration, Bruises.Decubitus, Open areas, Skin tear. This area lacked evidence of any skin impairments. An additional subsection labeled If alteration in skin noted was treatment or monitoring setup? was checked as Not Applicable; however, the next subsection related to Skin Comments identified Redness on the buttocks. This data collection form lacked any additional details related to the redness or further actions taken in response to the redness identification, nor did it identify the groin radiation dermatitis identified on 10/8/25. R1's 48 Hour [Baseline] Care Plan, dated 10/10/25, completed by RN-B, identified R1 had alterations in her skin integrity related to perineal and buttock wounds. The goal was to have this resolved by next review with the following triggered interventions: dietary interventions, including encourage supplements as ordered, weekly skin measurements and assessment of wound, monitor for skin breakdown for signs/symptoms of infection with reports to provider, document on skin condition and keep provider updated on any changes, wound care follow, treatment to open areas per order, turn and reposition or reminders to offload every two to three hours and as needed, pressure redistribution mattress to bed, and pressure redistribution cushion to wheelchair and chair. R1's Admission/Initial Data Collection form, completed on 10/10/25, lacked information related to perineal and buttock wounds: only buttock redness. R1's October 2025 Treatment Administration Record (TAR), directed a weekly skin inspection due on 10/11/25, and a skin assessment form to be completed by a licensed nurse. The task was signed off by RN-C; however, there was no skin assessment form in R1's medical record. A Task report identified R1 refused her 10/11/25 shower/bath. R1's 10/11/25 progress note, completed by RN-C, identified wound care was provided; however, the note lacked any additional information on which wound(s) and/or the wound(s) status. In addition, the note lacked information related to the Weekly Skin Assessment process. A progress note, dated 10/12/25, indicated RN-D questioned a nursing assistant about R1's bathing since admission. This interaction identified R1 received a shower on 10/10/25 with no skin concerns identified at that time, [despite the 10/10/25 skin assessment and baseline care plan that identified skin impairments were present that day]. R1's Braden Evaluation (scale for predicting pressure ulcer risk), dated 10/12/25, indicated the following:-Sensory Perception: No impairment. -Moisture: Rarely Moist.-Activity: Walks occasionally-Mobility: Slightly Limited. Makes frequent though slight changes in body or extremity position independently.-Nutrition: Adequate.-Friction and Shear: Potential problem. This scoring identified a score of 19 which equated to a lower risk. A progress note, dated 10/13/25, identified R1 was assessed by nurse practitioner (NP)-A and found to have peri area (layer of skin between genitals and anus) erythematous (abnormal redness or inflamed skin), which R1 identified was baseline secondary to radiation. There were no changes in the plan of care. The note lacked information related to the 10/10/25 buttock redness/wounds and/or that the buttock area was assessed and found free of concerns. R1's Clinical Nutrition Assessment, dated 10/14/25, identified the dietitian suggested a house supplement every day related to malnutrition. It was estimated that R1 met greater than sixty percent of her estimated needs through oral intake; however, the focus was to stay with good oral intakes and remain hydrated. The assessment indicated No additional nutrition concern at this time. The assessment lacked information related