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	06/25/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a dignified toileting experience for 2 of 3 residents (R5, R9) reviewed for incontinence care.Findings include:R5R5's admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.R5's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her head down and remained there until 2:25 p.m.During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.At 2:33 p.m., staff had still not assisted R5.During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5's room had a strong urine odor. When R5's brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.R5's care plan dated 6/24/26, identified an alteration in elimination and directed staff to use a full body lift for transfers. The care plan indicated R5 required assistance with pericare, bed mobility and assistance with movement in and out of bed.During interview on 6/23/26 at 4:10 p.m., registered nurse (RN)-A stated R5's toileting schedule was changed recently following a knee injury. RN-A said when a resident asked to be changed, staff should assist the resident as soon as they could get to them, depending on call lights. RN-A said waiting over two hours was unacceptable. RN-A further acknowledged she had noticed the urine odor in R5's room. During interview on 6/23/26 at 4:17 p.m., the director of nursing (DON) stated she expected staff to assist a resident as soon as possible if the resident asked to be changed. When asked about a reasonable time frame, the DON repeated as soon as possible. The DON said she definitely would have expected the resident to be assisted in less that an hour and a half and said if staff needed assistance they should have asked the management team for help.R9R9's admission Record indicated she admitted to the facility on [DATE]. R9's diagnosis included malnutrition, bladder dysfunction, urine retention and mild dementia.R9's admission MDS dated [DATE], identified intact cognition and indicated she required supervision/touching assistance for toileting. The MDS indicated R9 was frequently incontinent of bowel.R9's care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out of bed and transfers.A Grievance Form-Nurse/NA Behavior dated 6/22/26, indicated R9 reported on 6/22/26 at 7:00 a.m., NA-D had ripped off her brief very violently, threw it in the garbage and said, you can do this on your own. R9 did not want NA-D back in her room. A correlating Resolution Report dated 6/22/26, indicated the DON spoke with R9 who denied care concerns that morning.During interview on 6/24/26 at 3:15 p.m., R9 stated she had learned how to (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take care of herself except when she needed help with her catheter bag. R9 said a lady (NA-D) had been banned from her room and said a few days prior, she had been trying to get her pants down and had pushed her button. R9 said I don't know what set her off, she ripped my brief off. I thought she [NA-D] was going to slam me into a wall. R9 said she was scared like this and demonstrated by shaking her hands. R9 said she filed a complaint but wasn't sure if it went anywhere.A Grievance Form- Care Concern dated 5/20/26, indicated an unidentified resident reported on 5/20/26 at 2:00 a.m., she pushed her call light to be taken to the bathroom and stated the NA (NA-D) said she was unable to take her to the bathroom because she was the only NA on the floor. NA-D told the resident she could put on a brief and go to the bathroom in it. The resident went the whole shift without using the toilet. A correlating Resolution Report dated 5/22/26, indicated the DON interviewed NA-D who said there had been a miscommunication and said she had been trying to offer the resident other options.Resident Council Meeting Minutes for May 2026, indicated NA-D- very rude.During interview on 6/24/26 at 4:43 p.m., with the administrator and the DON, the administrator stated he needed to look more into how the facility addressed concerns related to NA-D and would get back to this surveyor. No follow up was received.Facility policy was requested but not received.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to accurately code a facility acquired pressure ulcer on the Minimum Data Set (MDS) for 1 of 3 residents (R4) reviewed for pressure ulcers.Findings include:R4's Transfer/Discharge Report printed 6/30/26, indicated she admitted to the facility 3/19/26. R4's diagnoses included vascular dementia, malnutrition and hemiplegia (paralysis or severe weakness affecting one side of the body) and hemiparesis (one-sided muscle weakness).R4's Wound Evaluation dated 5/28/26, identified a peri-anal posterior pressure ulcer, stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling).R4's care plan revised 6/21/26, indicated alteration in skin integrity related to overall decline in condition, current wound to coccyx. The care plan directed staff to document on skin condition and keep provider informed.R4's discharge MDS dated [DATE], indicated she did not have a pressure ulcer.Facility policy related to MDS coding was requested but none received. The administrator wrote in an e-mail on 6/30/26, the facility followed the Resident Assessment Instrument manual.

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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** Based on observation, interview and document review the facility failed to investigate the cause of an injury that resulted in pain and a change in transfer status for 1 of 1 resident (R5) reviewed with an injury which occurred during a transfer. Findings include:R5's admission Record indicated she admitted to the facility 3/22/21. R5's diagnosis included chronic kidney disease, obesity and dysphagia.R5's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required partial to moderate assistance to transfer.R5's care plan dated 10/1/24, identified a self-care deficit and an alteration in elimination and indicated she required assistance from one staff for bed mobility and toileting. The care plan was revised 6/24/26, and directed staff to transfer using a full body mechanical lift and two staff.R5's Progress Notes identified the following:6/16/26, R5 reported the p.m. staff had been very rude and said while transferring, the staff did not listen to her. R5 reported the staff moved too quickly resulting in pain to R5's left knee.6/16/26, Nurse practitioner visited for acute onset of left knee pain. Chart review indicated the pain started following a transfer the previous night. R5 was unable to specify exact mechanism of injury but stated the aide was not gentle. The pain involved the entire left leg but was most severe in the knee and slightly below. The left knee was swollen and painful with movement. R5 expressed concern regarding the aide who assisted her during the incident.6/19/26, Nurse practitioner (NP) visit note, indicated R5 endorsed that three days prior a staff member attempted to get her out of bed and ended up twisting her knee. Since then had been progressively worse. Staff reported R5 had been refusing to get out of bed due to pain. R5 reported staff had been attempting to help her out of bed and she twisted her knee. The pain had been getting progressively worse and she was unable to get out of bed due to the pain. Orders included limit weight bearing for two weeks and a knee immobilizer or brace. Findings suggested a ligament injury.During observation on 6/23/26 at 3:05 p.m., nursing assistant (NA)-B and NA-C prepared to transfer R4 using a mechanical lift. NA-B stated something happened when R5 had been transferred before she needed the lift and her knee twisted. R4 was saying ouch when staff touched her knee. During the transfer, R4 said, ouch, please. When staff rolled R4 in the bed, R4 said oh, it hurts so and continued vocalize pain throughout being rolled and changed in the bed.During interview on 6/23/26 at 4:10 p.m., registered nurse (RN)-A stated the previous week, R5 was being transferred and she kind of tweeked her knee. RN-A said the next morning R5 complained of knee pain and did not want to get out of bed. RN-A said R5 told her the transfer the evening before, Had not gone well.During interview on 6/23/26 at 4:17 p.m., the director of nursing (DON) stated R5 had reported knee pain and said they investigated the source of the pain. The DON said staff had gone in to transfer R5 and she had struggled to stand so the staff got help from another staff person and eventually used a mechanical lift. The DON said she interviewed R5 about the staff being rude during the transfer and said R5 liked things done a certain way and felt it was rude that staff had not followed her routine. The DON provided statements from a nursing assistant who had not cared for R5 that night and said R5 had first reported the concern to a nurse but she did not have a statement from that nurse. The DON said the other statements were in e-mails and she would look for them.During interview on 6/24/26 at approximately 8:00 a.m., the DON provided copies of handwritten papers, in her own handwriting, and said they were the statements from the other parties involved. The DON said because there was information in the e-mails that pertained to other things not involved in the investigation, she could not provide them.During interview on 6/24/26 at 12:10 p.m., with the administrator and DON, the administrator stated he would have to talk to corporate leadership about the e-mails and said it was not their policy to give out internal communication. The administrator returned a few minutes later and said there was nothing in the e-mails and said the DON had found the papers in a different file. The DON was asked why she told the surveyor the interviews were in an (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e-mail and the DON stated, I don't know why I told you that.During interview on 6/25/26 at 10:28 a.m., R5 stated since her knee injury, when the staff rolled her it hurt and said she couldn't get into the bathroom. When asked how her knee was injured, R5 stated the NA, Did not want to be told nothing, so the whole routine was wrong. R5 said the NA couldn't get her in bed and R5 told her she needed to get some help but the NA did not listen. R5 said NA eventually did get help. One NA was in front of her and the other NA was behind her and they were squeezing her around the arms. R5 said, she [NA] was very rude, and said, that's when the bad thing came. R5 said her knee had not hurt prior to that incident. R5 said, I didn't want to write her up, and said she was told they got rid of the NA. R5 said, I don?t want to have her again.Facility policy Abuse Prohibition/Vulnerable Adult Policy indicated the facility investigation team will review all incident reports including those that indicate and injury of unknown origin and determine if further investigation is needed. The facility will provide proper follow up communication related to the incident across all shifts.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure they maintained sufficient numbers of staff to assist 5 of 5 residents (R5, R6, R7, R8 and R9) in a timely manner. This had the potential to affect all residents residing on the 300, 400 and 500 units of the facility.Findings include: R5R5's admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.R5's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her head down and remained there until 2:25 p.m.During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.At 2:33 p.m., staff had still not assisted R5.During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5's room had a strong urine odor. When R5's brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.R6R6's admission record printed 6/30/26, indicated he admitted to the facility 2/26/25.R6's quarterly MDS dated [DATE], indicated R6's cognition was intact. R6 was independent with toilet transfers and toilet hygiene but required setup or clean-up assistance for personal hygiene. R6 was occasionally incontinent bowel and bladder.R6's care plan dated 5/21/25, identified an alteration in elimination related to decreased mobility. The care plan directed staff to assist with peri-cares, to provide incontinent products and assist to change as needed (PRN).During observation on 6/24/26 at 8:39a.m., R6 propelled himself from his room and told registered nurse (RN)-A he needed to go to the bathroom. RN-A told R6, I will find the girls.During interview on 6/24/26 at 3:02 p.m., R6 stated his call light had been on for over an hour that morning. R6 said it happened about once per week. R6 stated he had times when he had not made it to the bathroom on time because the call light was not answered and said it bothered him.R7 R7's admission Record printed 6/30/26, indicated he admitted to the facility 2/13/26.R7's quarterly MDS dated [DATE], indicated R7's cognition was intact. R7 required partial/moderate assistance from staff for transfers, dressing/undressing, toileting transfers and hygiene. R7 was occasionally incontinent of bladder and frequently incontinent of bowel.R7's care plan dated 4/27/26, identified and alteration in elimination and alteration in mobility. The care plan directed staff to assist with toileting and assist with movement in and out of bed.R8 R8's admission Record printed 6/30/26, indicated he admitted to the facility 2/6/24.R8's significant change MDS dated [DATE], indicated R8's cognition was intact. R8 required partial/moderate assistance for dressing/undressing and was independent with transfers and ambulation.R8's care plan dated 10/15/24, identified a self-care deficit and directed staff to assist with grooming, bathing and personal hygiene.During interview on 6/24/26 at 3:11 p.m., R8 said we can't get any help. R8 said today was so long he turned on his light because R7's light was not answered for so long. He [R7] told me this morning, he waited a long time to get help to get up and get ready for breakfast. R9R9's admission Record indicated she admitted to the facility 6/5/26.R9's admission MDS dated [DATE], indicated R9's cognition was moderately impaired. R9 required partial/moderate assistance with dressing/undressing, supervision or touching assistance with transfers and toileting hygiene. R9 was frequently incontinent of bowel.R9's care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of bed and transfers.During interview on 6/24/26 at 3:15 p.m., R9 stated the call light was on a long time and said it was not the staffs' fault, they are busy. R9 said she had a bowel movement and had been waiting to get help to get cleaned up.Call light logs were reviewed for the following rooms for 6/24/26 from 7:00 a.m. - 11:00 a.m.room [ROOM NUMBER]B (R6), call light was cleared at 8:56 a.m. The call light had been on for 48 minutes and 17 secondsroom [ROOM NUMBER]B (R7), call light was cleared at 9:19 a.m. The call light had been on for 76 minutes and 30 seconds.room [ROOM NUMBER]A (R8), call light was cleared at 8:37 a.m. The call light had been on for 55 minutes and 43 seconds.room [ROOM NUMBER]B(R9), call light was cleared at 7:28 a.m. The call light had been on for 57 minutes and 37 seconds.Resident Council Meeting Minutes reviewed for 1/2026 through 6/2026 revealed the following:1/13/26, long call light wait times. One resident indicated they waited so long they had sores on their bottom. A Resident Council Response Form dated 1/22/26, reviewed call light logs for trends and patterns, education completed related to ensuring timely responses to the best of ability for shifts with trends noted.2/17/26, ongoing concerns about long call light wait times. Resident Council Response Form dated 3/15/26, indicated several new staff, management team was working with current and new team members to promote teamwork and division of tasks for efficiency.3/10/26, long call light times while on toilet, not getting washed up on evening shift. Resident Council Response Form dated 3/11/26, indicated residents complained of not getting washed up in the a.m. or p.m., several stated on p.m. they almost never got washed up. Reported by five residents. Resident Council Response Form dated 3/12/26, indicated care management to address residents not getting washed up at huddle. A second Resident Council Response Form dated 3/12/26, indicated residents being left on toilet, long call light wait times leading to sore bottoms and self-transferring of residents. The response indicated all staff education completed related to teamwork and collaboration to ensure task completion implemented at huddle. A third Resident Council Response Form dated 3/12/26, indicated residents stated they had not been getting showers. One family member had to call so the residents could get a shower, had been two weeks. Resident had been told staff did not have time. The form indicated, would review at huddle, care managers had been implementing a check in process with the NA's and if showers had been completed.4/14/26, 300, 400 and 500 units not receiving a.m. or p.m. cares, not getting washed up. Residents wanted to see management on the floor. Resident Council Response Form dated 4/20/26, indicated residents on the 300, 400 and 500 units stated they could not remember the last time they had been washed up in the a.m. or p.m. shifts. The form indicated staff received education on proper hygiene for all residents and explained residents right to be properly cleaned before bed and when they got up. A second Resident Council Response Form dated 4/20/26, indicated residents would like to see management on the floor and wanted to know why they did not help out. The form indicated upper management to round prior to morning meeting and throughout the day to ensure residents could put a name and face with the management team. A third Resident Council Response Form dated 4/20/26, indicated residents wanted to know who filled in when staff were on break or if they were just left short staffed on the floor. This was causing long wait time for the bathroom. The form indicated residents were informed that floor staff were to inform each other when they went on break and to cover for each other. Staff were to ask management for assistance when they needed help. Another Resident Council Response Form dated 4/20/26, indicated residents wanted proof of follow through and felt they were being pushed off. Response indicated the administrator spoke with residents during several activities and explained they were not being pushed off and there were a lot of moving parts.5/19/26, residents not getting washed up on day and evening shift on the 500 unit and needing the bathroom while staff is still in the dining room. Resident Council Response Form dated 5/20/26, indicated management and office staff would be on the floor and designated float to tend to residents who were not in the dining room. A second Resident Council Response Form dated 5/20/26, indicated residents stated they are still not getting washed up in the a.m. or p.m. and only one certain NA who worked on the overnight shift would perform a.m. cares. The form indicated care managers had a meeting to ensure they were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rounding and laying eyes on the staff to ensure residents were properly cleaned and had clean clothing.6/9/26, cares not getting done, residents sitting on toilet too long. Resident Council Response Forms had not been completed.During interview on 6/24/26 at 4:43 p.m., with the administrator and the director of nursing (DON), the administrator said a little over a month ago they realized they had some grievances related to call lights. The administrator said they formed a team meeting every Friday and went over call lights from the previous week. The DON said they identified a trend in the morning when everyone wanted to get up and were looking at adjusting staff. The DON said mealtimes were the biggest trend so they had looked at increasing management presence to round on the units, answer call lights and if able, complete the task. The administrator said when they pulled the call light logs that morning he was surprised and thought they had been doing pretty good. The administrator said staff was based on per patient days (PPD) but said he did not know the breakdown. The administrator said he felt they had enough staff.During interview on 6/25/26 at 9:16 a.m., NA-E stated the previous day she had been assigned on the 400 unit and worked for about an hour. NA-E said she was told they were overstaffed and she was sent home. NA-E said she was not able to complete all her work before being sent home.During interview on 6/25/26 at 9:41 a.m., NA-F stated she was not all her assigned work during her shift.NA-F said breakfast was 8:00 a.m. and said the NAs were still getting people up and dressed at that time. NA-F said two day shift staff had been sent home early the previous day [6/24/26].During interview on 6/25/26 at 9:11 a.m., licensed practical nurse (LPN)-A stated management told staff they could only have three NA's to cover the 300,400 and 500 units because of census. LPN-A stated she tried the best she could to help out and said it was hard because a lot of residents required assistance from two staff. LPN-A said the long call light wait times was definitely not uncommon.A policy related to sufficient staff was requested but not received.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview and document review the facilities Quality Assurance and Performance Improvement (QAPI) committee failed to address resident concerns related to call light wait times which resulted in cares not being performed and toileting tasks not being completed in a timely manner. This had the potential to affect all residents in the facility who required assistance from staff to completed activities of daily living. Findings include: Refer to F725:Based on observation, interview and document review the facility failed to ensure they maintained sufficient numbers of staff to assist residents in a timely manner on the 300, 400 and 500 units of the facility.During document review and interview on 6/25/26 at 1:38 p.m., with the administrator, the 2026, QAPI notes related to staffing were reviewed. The administrator stated in January the notes identified concerns related to staffing as it related to new hires. The administrator said nothing was noted related to call lights for the month of February. In March, the administrator said the committee discussed call light times and training staff to leave lights on until cares were completed. The goal for responding to call lights was nine minutes. In April, long call light times were noted, and the nurse managers were expected to follow-up. The administrator stated in May, long call light times were again identified and said the follow-up was the same as the previous month. The administrator said in June, again long call light wait times were identified and the committee discussed pulling the call light reports each day. The administrator stated he had reviewed the call light reports, and the last few weeks had been really good. Long call light wait times were noted around mealtimes, the plan included to increase management staff on the floor to ensure call lights were being answered and assist with getting residents to and from meals. The administrator stated there had not been discussion related to increasing the amount of staff in the facility related to the concerns.Facility policy Quality Assurance and Performance Improvement dated 2/2025, indicated the facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as:Tracking and measure performance; Establishing goals and thresholds for performance measurement; Identifying and prioritizing quality deficiencies; Systematically analyzing underlying causes of systemic quality deficiencies; Developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.