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	08/08/2024

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** 20794 Based on observation, interview and document review, the facility failed to ensure appropriate wheel chair (WC) positioning was maintained for 1 of 2 residents (R45) in the sample reviewed for positioning. Findings include: R45's most current quarterly minimum data set (MDS), dated [DATE], documented R45 was severely cognitively impaired and was dependent with most of his activities of daily living. R45's Medical Diagnosis sheet printed 8/7/24, indicated diagnoses of morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease, and dementia with other behavioral disturbances. During observation on 08/05/24 at 2:28 p.m., R45 was observed in his WC. near the central dayroom. R45 was a sleep, leaning back in his WC. The vinyl back of the WC lined up with R45's mid-back, which when sleeping, caused R45 to be arched over the back of the WC. When R45 leaned back, the vinyl back was pushed down approximately two inches. During breakfast observation on 8/6/24 at 8:57 p.m., R45 was finishing his breakfast, as he was leaning back in his WC. R45 stated he was sore today. He had pain in his back. During observation on 8/07/24 at 7:45 a.m., R45 was again observed sitting at a dining room table sleeping, leaning back in his WC. R45 was leaning so much, he was facing the ceiling and snoring. The vinyl back appeared to be pressed down approximately two inches down mid-back. R45 was in such a reclined position, resident's shoulders and head were over the back support of his WC. R45's medical records indicated R45 was last seen by occupational therapy in September 2023. An evaluation (screened) for needs was completed, however it was decided R45 did not require any treatment or interventions at that time. (continued on next page)

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
	245325	A. Building B. Wing	08/08/2024

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	During observation and interview on 8/8/24 at 9:58 a.m., R45 was sitting in his WC next the the family room on the unit, sleeping and leaning back. The contracted occupational therapist (OTR) performed a brief visual screen of R45. OTR stated, although R45's WC was wide enough in the seat, the back was too narrow and too short, which was not providing sufficient support for R45. OTR stated she had only been at the facility for a couple of months, and had never worked with R45, nor was informed of any WC issues with R45. A review of the facility's policy, entitled: Activities of daily Living (ADLs) / Maintain Abilities Policy (last updated 5/9/24) documented the following: 1. Based on a comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living to not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.

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	08/08/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49654 Based on observation, interview and document review, the facility failed ensure medications were administered safely for 3 of 6 residents (R19, R40, R61) reviewed for medication administration. Findings include: During observations on 8/7/24 at 9:29 a.m., trained medication aide (TMA-D) stood by a medication cart outside the dining room. TMA-D opened the top drawer of the cart and three medication cups were observed in the front compartment. Each cup had an unidentified number of pills of varying size and colors. A small slip of paper approximately the size of a postage stamp was on top of each medication cup and identified the initials for R19, R40, and R61. TMA-D stated they had been instructed to dish up three residents' medications at a time and to document each medication as administered in the electronic medical record (EMR). TMA-D would then administer the medications to the residents. Review of the EMR indicated TMA-D had signed off R19's, R40's, and R61's morning medications, however, the medications had not been administered. TMA-D confirmed the medications had not been given. On 8/7/24, at 9:50 a.m., TMA-D opened the medication cart drawer, removed the prefilled medication cups for R19 in their room. Moments later, TMA-D exited R19's room without the medications. On 8/7/24, at 9:56 a.m., TMA-D obtained the medication cup for R61 and entered R61's room. Moments later TMA-D exited R61's room without the medication. During interview on 8/7/24 at 10:51 a.m., the director of nursing (DON) stated the staff were to dish up one resident's medications at a time, administered them to the resident and then sign the EMAR after the resident had received the medication. This was to ensure each resident received their medications. Pre-dishing medications was not an acceptable practice and put the residents at risk for potential medication errors. The Medication Administration -General Guidelines policy dated December 2019, directed authorized staff to ensure medications were administered as prescribed in accordance with the five rights of medication administration. The five rights were identified as: right resident, right drug, right dose, right time and right route. The policy also directed medications administered by mobile medication cart were to be taken to the resident's location and medications were to be administered at the time they were dispensed. The policy specifically directed the staff to refrain from pre-pouring medications in advance of the medication pass or for more than one resident at a time.

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	08/08/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49654 Based on observation, interview and document review, the facility failed to ensure eye drops were labeled for specific resident or dated with opened on date to ensure expired products were not administered for 2 of 2 residents (R8, R16) reviewed for medication storage and labeling. Findings include: During observation on 8/7/24 at 07:12 a.m., a review of the medication carts was performed with licensed practical nurse (LPN-A). The top drawer of the 500 wing cart contained two open multidose bottles of artificial tears. Neither bottle identified the resident to whom the medication was to be given to, the date the bottle had been opened or a date which would indicate when the medication would expire. LPN-A stated the bottles were stock medications which had been opened for R8 and R16 as they were located in a individually divided sections of the cart for R8 and R16. During interview on 8/7/24 at 09:06 a.m., LPN-A stated staff used all stock medications for things like eye drops and staff could check on the electronic medication record (EMR) to clarify the medication was on the resident's medication list. LPN-A stated staff should be putting an opened on and expiration date sticker on the bottle. LPN-A then instructed trained medication aide (TMA)-C to place an opened 8/7/24 on R16's bottle. TMA-C did as directed and dated R16's bottle as 8/7/24, however, the exact date of when the bottle was opened was unknown. During interview on 8/7/24 at 10:51 a.m., director of nursing (DON) stated staff should use facility supply of artificial tears which were packaged in individual dose vials. DON stated the facility supply box is dated with an Opened on and Expires on sticker. The DON's expectation of staff was to have them use individual dose vials and follow the open date and expiration dates written on the containers to ensure the residents did not receive expired medications. The Medication Storage in the Facility policy dated January 2018, indicated when the original seal of a manufacturers container or vial is initially broken, the container or vial will be dated. The nurse will place a date opened sticker on the medication and enter the date opened and the new date of expiration, noting the best stickers affix contain both a date opened and expiration notation line. The policy directed the expiration date to be identified as 30 days from the time the medication was opened.

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	08/08/2024

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 20794 Based on observations, interview and document review the facility failed to submit complete and accurate direct care staffing information, including information for agency and contract staff, during 1 of 1 quarters (Quarter 2: January 1 - March 31, 2024), reviewed for payroll based journal (PBJ) for excessively low weekend staffing. Findings include: Review of the staffing schedules and timecard verifications with the facility for Quarter 2 identified the facility had licensed nursing staff, 24 hours per day 7 days per week, and 8 consecutive hours per 24 hours of registered nurse (RN) coverage documented. Observations during the facility's recertification survey (8/5/24 through 8/8/24) quality of care was observed. Residents were all dressed and groom well, call lights were answered within acceptable time frames. In further review of the facility's weekend schedules, during the quarter triggered by the facility's PBJ report, it was noted that several of the weekends had two extra staff scheduled, even though there were floats scheduled to assist staffing levels normally scheduled. The extra staff scheduled were not listed as being in training, as noted on other schedules reviewed. Schedules during the same quarter indicated, weekdays matched the weekends where the extra staff were not scheduled. During interview on 8/8/24 at 9:30 a.m., the director of nursing (DON), corporate registered nurse (CRN), corporate nurse lead (prior DON - CNL), the administrator in training (AT) and human relations (HR) were present. CRN stated that HR works with corporate in gathering the the facility's staffing information for submission in the PBJ report. HR stated the only information HR was responsible to gather is that of agency staff and contractual staff. HR stated corporate utilized the payroll system for gathering facility staff hours. HR only submited non-facility staff to corporate for inclusion for the PBJ. CNL, who had been the director of nursing during the quarter in question, stated the scheduler at that time, had over scheduled on some weekends. CNL stated the scheduler, when there were open shifts, would first schedule agency staff. When staff would then volunteer, many times, scheduler would forget to cancel the agency staff. This may have been why some weekends appeared more heavily scheduled. In review of the facility's policy, entitled: Payroll Based Journal Policy (undated) documented the following: (continued on next page)

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	08/08/2024

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Payroll Based Journal Staffing Data Submissions are to be completed by all of Monarch Healthcare Management's Long-Term Care Facilities. Monarch follows the Federal Policy Manual created by the Centers for Medicare & Medicaid Services in regards to Electronic Staffing Data Submission Payroll-Based Journal. Monarch's Staffing data is generated and exported from out SmartLinx Scheduling Software and the imported into CMS according to the Submission guidelines provided by CMS. Submissions are to be completed by the Due data for the correct Fiscal Quarter according to the deadlines provided from the Centers for Medicare & Medicaid Services.

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	08/08/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49654 Based on observation, interview and record review, the facility failed to follow infection control practices for administration of eye drops to 1 of 2 residents (R16) reviewed for administration of eye drops. Findings include: On 8/7/24 at 8:59 a.m., during an observation of medication administration, trained medication aide (TMA-C) approached R16 and informed R16 it was time for administration of artificial tears. TMA-C donned a glove and gently pulled the inner corner of R16's left lower lid down and attempted to place one drop in the inner aspect of the lower lid. R16 squeezed their eyes shut. TMA-C gently touched the tip of the medication bottle to the inside of R16's lower left lid. TMA-C then repeated the process for the right eye. TMA-C stated they were unaware the bottle had touched R16's eye lid while administering the medication. TMA-C confirm if the bottle was contaminated during administration, it should no longer be utilized as TMA-C placed the bottle back into the medication cart. During an interview 8/7/24 at 10:51 a.m., the director of nursing (DON) stated the staff were to follow proper infection control and medication administration practices during eye drop administration. This would include ensuring the tip of the bottle did not touch the resident's eye lid. DON confirmed if the eyelid was touched with the bottle, the entire bottle would be considered contaminated and should be discarded. The Specific Medication Administration Procedures -Eye Drop Administration policy dated December 2019, directed the staff to ensure the tip of the dropper does not touch the eye or any other surface.