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	09/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to update the provider as ordered when resident gained weight for 1 of 1 resident (R54) reviewed for dialysis. R54's admission Minimum Data Set (MDS) dated [DATE], indicated R54 was cognitively intact, required extensive assistance with activities of daily living (ADLs). R54 had diagnoses which included end stage renal disease, vascular prosthetic device, anemia, cardiomegaly and hypertension. R54's order summary printed 9/17/25, indicated R54 had an order dated 8/28/25, for weight gain - call your provider if you gain 3 pounds or more overnight, or gain 5 pounds in a week. A review of R54's weight record identified on 8/31/2025, R54 weight was 95.4 pounds (lbs.). When weighed on 9/1/2025, R54 was 103.6 lbs. - a 7.2-pound weight gain overnight. On 9/2/2025 R54's weight was 100.0 lbs. then on 9/3/2025, R54's weight was 105.0 lbs. - a five-pound weight gain overnight. On 9/4/2025, R54's weight was 99.6 lbs., then on 9/5/2025, R54's weight was 102.6 lbs. - a three-pound weight gain overnight. On 9/11/2025, R54's weight was 99.0 lbs., then on 9/12/2025, R54's weight was 106.6 lbs. - a weight gain of 6.6 pounds overnight. On 9/14/2025, R54's weight was 104.0 lbs., then on 9/15/2025, R54's weight was 107.2 lbs. - a weight gain of three pounds overnight. R54's medical record was reviewed and lacked any evidence the facility had contacted R54's physician to inform them of R54's weight gains. Progress note dated 9/7/2025 at 1:31a.m., indicated R54 complained of shortness of breath and difficulty falling asleep. R54 was placed on oxygen.Progress note dated 9/8/25 at 6:41 a.m., indicated R54 complained of shortness of breath and requested oxygen. When interviewed on 9/16/2025 at 1:55 p.m., licensed practical nurse (LPN)-A stated R54 complained of a hard time breathing which started the day before going to dialysis. LPN-A was not sure if R54 had parameters regarding weight gain. LPN-A stated dialysis nor the provider had been updated regarding R54 having complained of having a hard time breathing or weight gains. When interviewed on 9/16/2025 at 3:08 p.m., registered nurse (RN)-B stated when R54 went two days between dialysis runs her weight increased and R54 complained of shortness of breath. RN-B did not believe R54 had weight parameters, RN-B reviewed R54's medical record, verified R54 had an order to update provider with weight gain of three or more pounds overnight or five pounds in a week. When interviewed on 9/17/2025 at 1:15 p.m., registered dietician (RD) from dialysis center stated R54 has had weight gains that were large, the weight gains were difficult to safely remove during dialysis, the fluid overload between runs could be related to her complaints of shortness of breath. When interviewed on 9/17/2025 at 2:00 p.m., RN-A stated the expectation was to update the provider and/or dialysis when R54 had a weight gain of three pounds overnight or five pounds in a week. RN-A stated a respiratory assessment for R54 had not been completed, RN-A had not heard about R54 having complained of shortness of breath/difficulty breathing between dialysis days. Facility policy regarding change in condition/provider updates was requested, however, none was provided.

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
	245325	A. Building B. Wing	09/17/2025

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 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 observation, interview and document review, the facility failed to ensure the resident minimum data set assessments (MDS) were accurately documented for 1 of 3 residents (R4) in the sample who were reviewed for weight loss. Findings include: R4's Diagnosis Report (print date of 9/17/25) documented the following diagnoses: type 2 diabetes and morbid (severe) obesity due to excess calories. R4's quarterly Minimum Data Set (MDS) dated [DATE], R4 was documented as moderately cognitively impaired and was dependent on staff with dressing, bathing, bed mobility and transfers. R4's MDS further indicated in Section K Swallowing / Nutritional Status, resident had experienced a significant weight loss, recording the weight of 356 pound (lbs). In review of the facility's Resident Matrix (a document created from resident MDS data collected) also indicated R4 had a significant weight loss. During initial screening and interview on 9/14/25 at 1:09 p.m., R4 sat in a room recliner watching TV. R4 appeared to be significantly overweight. R4 stated he did not feel he received adequate amounts of food at meals, being his main concern. In review of R4's Clinical Nutritional Evaluation (dated 8/26/25) documented the following:[R4] has been doing fairly well in the facility over past quarter. Remains on 2 [gram] [sodium] diet order, regular textures, thin liquids, which provides [approximately] 2000 [kilocalories], 90 [grams] protein. Intakes have been great, averaging [approximately] 76-100%. [Weight] has a trigger for 5% loss. Loss is a healthy one due to current weight and [BMI - body mass index]. Current [weight] 356 [lbs], 30 [days]: 377 [lbs], 180 [days] 357 [lbs], [height]: 72 inches, BMI: 48.3, indicating obesity. Anticipated weight fluctuation with use of diuretic. No additional nutritional concerns at this time. RD to review / follow up as needed. In review of R4's Vitals section in Point Click Care (PCC - electronic medical record), the facility had recorded the following weights in the look back period, used to assess R4's nutritional concerns for the 9/05/25 quarterly MDS: 9/9/2025 13:55 365.4 lbs 8/26/2025 13:39 357.4 lbs 8/24/2025 12:57 356.0 lbs 8/22/2025 11:21 364.4 lbs 8/19/2025 13:59 366.2 lbs In an interview on 9/17/25 at 10:40 a.m., the MDS coordinator (MDSC) stated nursing does not assess or fill out Section K of the MDS, but rather the culinary services director (CSD). During interview on 9/17/25 at 10:59 a.m., the CSD, after reviewing R4's MDS in PCC, verified CSD used R4's 8/24/25 weight of 356 lbs and had triggered, after assessing, a significant weight loss. CSD then looked at R4's Vitals section in PCC and noted after CSD had completed Section K for R4's quarterly MDS, the registered dietitian (RD) had since reviewed the weights recorded and Struck Through the weights from 8/24/25 and 8/26/25 documenting them as inaccurate. CSD stated at the time of the quarterly MDS, the weight of 356 lbs had not been struck through and assumed it was an accurate recording. CSD stated the facility holds weekly Weight Loss Meetings, and at that time, he was not aware that R4's weight was inaccurate. In review of a progress note for R4, dated 9/17/25 at 11:50 a.m. documented the following: Nutrition communication: RD met with [interdisciplinary team] [related to] weights (9/15). Weights struck out from (8/24-8/26) [related to] 8 [lb] discrepancy. Resident weight is stable from 7/25-8/22. RD suggests inaccurate weights [related to] stability of weights, and with new obtained weight (9/16) showing continuing of stability of weights. No additional nutrition concern at this time. RD to review / follow up as needed. In review of the facility policy, entitled: Weight Policy (revised 5/1/24), documented the following:10. The registered dietitian (RD) and/or registered dietic technician (DTR) shall review residents who trigger for significant weight gain or loss. Significant is defined as a person with 5% weight change over 30 days, 7.5% weight change over 90 days, or 10% weight change over 180 days.AND11. The interdisciplinary team and/or facility designee shall review weights for significant weight changes and will be discussed to determine individualized care plan interventions and documented in the electronic medical record.

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	09/17/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) reassessment was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided for 1 of 3 residents (R53) reviewed for PASARR. Findings include: R53's quarterly Minimum Data Set (MDS), dated [DATE], identified R53 had intact cognition and required assistance with activities of daily living (ADLs). R53's diagnoses included schizoaffective disorder - bipolar type, hypertension, ulcerative colitis, diabetes mellitus, anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia and post traumatic stress disorder (PTSD). R53's pre-admission screening (PAS), dated 3/30/21, indicated R53 required a Level II assessment for mental illness to be done before admission to a nursing home. PAS further indicated R53 was in assisted living with an admission to the nursing home on 4/2/21 with an anticipated length of stay listed, Less than 30 Days. R53 was also noted to have a diagnosis of schizoaffective disorder, depressive episode and anxiety disorder. R53's Level II Preadmission Screening for Persons with Mental Illness Determination for Nursing Facility Admission, completed on 3/31/21, indicated admission is approved for post-hospital rehabilitative services for 30 days. This person may have a mental illness and may need specialized services, by [but] meets the requirements for post hospital rehabilitation. Further assessment and service plan changes must be documented upon a change in the resident's condition or when the nursing facility (NF) stay is anticipated to exceed 30 days. The NF is responsible for alerting LMHA to such changes. During interview on 9/17/25 at 9:47 a.m., social services director (SSD) stated being unaware of R53's Level II assessment being limited to a 30-day admission. SSD reviewed R53's Level II assessment and confirmed it was limited to a 30-day admission. SSD stated Senior LinkAge Line should have been contacted when R53 stayed in the nursing home past 30 days. A facility policy was requested but was not received.

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	09/17/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to promote healing of pressure ulcer for 1 of 1 resident (R1) in accordance with the individualized care plan.Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R1's diagnoses included pneumonitis (an inflammation of the lungs) due to inhalation of food and vomit, atrial fibrillation (heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly), diabetes mellitus (chronic metabolic disorder characterized by high blood sugar (glucose) levels that persist over time), thyroid disorder (condition where the thyroid gland produces an abnormal amount of thyroid hormones), seizure disorder (sudden burst of electrical activity in the brain), anxiety disorder, chronic obstructive pulmonary disorder [COPD] (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), hypoxemia (condition where there is an abnormally low level of oxygen in the blood), dysphagia (difficulty or pain when swallowing food or liquids, leading to symptoms like coughing, choking, and a sensation of food being stuck) and unspecified intellectual disabilities. MDS indicated R1 was at risk for the development of pressure ulcers. R1's care plan, undated, identified R1 had a pressure ulcer to coccyx (small triangular bone at the base of the spinal column) and left medial gluteus (left buttock) and was at a risk for altered skin integrity and pressure injuries and directed staff to turn and reposition R1 every two to three hours and as needed while in bed and/or wheelchair. During continuous observation on 9/16/25 from 12:31 p.m. to 4:09 p.m. R1 was observed to be seated in a Broda (reclining wheelchair with bilateral supportive cushions) chair. At 12:31 p.m., R1 was sitting in the living room area with other residents. At 12:36 p.m., unidentified staff assisted R1 to the dining room to eat. At 12:39 p.m., R1 was sitting in dining room eating with staff assistance. At 1:00 p.m., R1 was assisted back to living room area. At 1:22 p.m., R1 continued to sit in the living room area. At 1:25 p.m., staff assisted R1 back to her room. At 1:58 p.m., R1 was sitting in her Broda chair, in her room, in the same position. At 2:09 p.m., R1 remained in room watching television. At 2:21 p.m. R1 remained in room watching television. At 2:52 p.m., hospice chaplain entered R1's room and sat next to R1 and was talking and singing with R1. Hospice chaplain did not touch or reposition R1 during interaction. At 3:03 p.m., hospice chaplain left room. At 3:19 p.m., R1 remained in room watching television. At 3:41 p.m., R1 remained in room watching television. At 3:47 p.m., activity aide entered R1's room and asked if R1 would like to attend activities, with R1 grunting and activity aide left room. At 3:52 p.m., R1 remained in room watching television. At 4:09 p.m., registered nurse (RN)-C went with surveyor into R1's room to lay her in bed and access her skin. During interview on 9/16/25 at 3:52 p.m., licensed practical nurse (LPN)-A stated R1 was unable to reposition herself in her broda chair and needed staff to assist with repositioning. LPN-A stated R1 was to receive assistance with repositioning every two hours due to significant pressure ulcers. LPN-A was not sure the last time R1 was repositioned During observation and interview on 9/16/25 at 4:09 p.m., RN-C assisted nursing assistant (NA)-A with lying R1 down in bed. R1 had reddened creases approximately one-half to one inch above pressure ulcer that was located on R1's spine. RN-C stated it appeared the indentations were from where R1's shirt and sling were sitting when she was in broda chair. Area around pressure ulcers were reddened but were blanchable. Pressure ulcer on R1's coccyx was reddened and had no bandage or dressing present. During interview on 9/16/25 at 4:20 p.m., nursing assistant (NA)-A stated R1 was unable to reposition herself in her broda chair and needed staff to assist with repositioning. NA-A stated R1 was to receive assistance with repositioning every two hours due to her sores. During interview on 9/17/25 at 2:52 p.m., director of nursing (DON) stated she expected staff to turn and reposition residents as indicated in the resident's care plan. DON stated the time between repositioning is determined per resident and resident specific concerns. DON stated it was (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	09/17/2025

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	important to ensure the resident is receiving the appropriate care for healing of pressure ulcers. The facility Care Planning Policy, dated 11/24, indicated the facility would have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. A policy regarding re-positioning was requested but was not received.

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	09/17/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services were provided in accordance with professional standards of practice for 1 of 3 resident (R1) reviewed for oxygen therapy. Specifically, the facility administered oxygen without a physician's order specifying the liter-flow rate and failed to ensure the resident's portable oxygen tank was filled and available for use. These deficient practices created the potential for improper oxygen delivery, respiratory compromise, and delayed access to oxygen during mobility or emergencies.Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R1's diagnoses included pneumonitis due to inhalation of food and vomit (inflammation of the lungs caused by accidental aspiration of food or gastric contents), atrial fibrillation (an irregular heart rhythm affecting blood flow), diabetes mellitus (a chronic disorder causing elevated blood sugar), thyroid disorder (a condition affecting thyroid hormone production and metabolism), seizure disorder (a neurological condition causing recurrent seizures), anxiety disorder (a mental health condition causing excessive worry or fear), COPD (chronic obstructive pulmonary disease, a progressive lung disease causing airflow limitation), hypoxemia (low oxygen levels in the blood), dysphagia (difficulty swallowing, increasing aspiration risk), and unspecified intellectual disabilities (significant limitations in intellectual functioning and adaptive behaviors).Record review on 9/16/25, revealed R1 had a physician's order dated 7/6/25, for oxygen continuous via nasal cannula wean as able every shift. The order lacked required specifications for liter-flow rate, usage parameters, or maximum dosage. No additional clarifying orders were found in the medical record.During observation on 9/14/25 at 10:41 a.m., R1 was seated in a Broda chair receiving oxygen via nasal cannula. The oxygen concentrator was running at two liters per minute (2L/min). There was no physician order directing staff to administer oxygen at 2 L/min, and there was no documentation indicating who determined or adjusted the flow rate.During observation on 9/15/25 at 5:25 p.m., R1 was seated in a Broda chair in the dining room receiving oxygen via nasal cannula connected to a portable oxygen tank. The portable tank was running at three liters per minute (3L/min). There was no physician order directing staff to administer oxygen at 3L/min, and there was no documentation indicating who determined or adjusted the flow rate.During observation on 9/16/25 at 10:16 a.m., R1 was lying in bed receiving oxygen via nasal cannula. The oxygen concentrator was running at 2.5 liters per minute (2.5L/min). There was no physician order directing staff to administer oxygen at 2.5L/min, and there was no documentation indicating who determined or adjusted the flow rate.During observation on 9/16/25 at 12:31 p.m., R1 was seated in a Broda chair in the living room receiving oxygen via nasal cannula connected to a portable oxygen tank. The portable tank was running at 3L/min. Again, there was no physician order directing staff to administer oxygen at 3L/min, and there was no documentation indicating who determined or adjusted the flow rate.During a separate observation on 9/16/25 at 12:39 p.m., R1 was seated in a Broda chair with a portable oxygen tank hanging on the back of the chair. The tank gauge showed the tank was almost empty. At 1:00 p.m., R1 was assisted to the living room area. Staff had not identified or replaced the nearly empty tank, leaving R1 without access to portable oxygen during transport, movement away from the concentrator, or in the event of an emergency requiring immediate oxygen support. At 1:22 p.m., R1 remained seated in the living room and appeared to be short of breath. At 1:25 p.m., the surveyor informed licensed practical nurse (LPN)-C of R1's status, and LPN-C confirmed the portable tank was empty. LPN-C checked R1's oxygen saturation, which was 90% on room air. LPN-C assisted R1 back to her room and connected her to the in-room oxygen concentrator at 3L/min.During an interview on 9/16/25 at 3:52 p.m., LPN-D stated R1's oxygen flow rate fluctuated, and she was unsure what the correct flow rate should be. LPN-D stated R1's flow had previously been set at 1.5 to 2L/min before LPN-D left for vacation. LPN-D went to R1's room and (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	09/17/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed the concentrator was set at 3L/min. LPN-D confirmed there were no specific liter-flow instructions in the physician order and stated staff use their judgment in determining the rate.During an interview on 9/16/25 at 4:56 p.m., the assistant director of nursing (ADON) stated oxygen was administered to R1 daily and acknowledged staff typically left the flow rate set by the previous shift. The ADON confirmed there was no written guidance directing staff on adjusting oxygen flow. The ADON stated R1's oxygen order indicated continuous use, but staff were not able to determine what liter flow should be used and needed a specific physician order.During an interview on 9/17/25 at 2:52 p.m., the Director of Nursing (DON) stated all oxygen orders must include the liter-flow rate and confirmed R1's order was incomplete. The DON stated staff should not administer or adjust oxygen without a complete order. The DON further stated portable oxygen tanks should never be empty, must be checked each shift, and must be replaced before becoming depleted.A policy regarding oxygen administration was requested but was not received.

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	09/17/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to consistently track and monitor fluid intake for 1 of 1 residents (R54) on fluid restrictions reviewed for dialysis. In addition, the facility failed to ensure communication forms were consistently filled out with updates or reviewed following dialysis for 1 of 1 residents (R54) reviewed for dialysis.R54's admission Minimum Data Set (MDS) dated [DATE], indicated R54 was cognitively intact, required extensive assistance with activities of daily living (ADLs). R54 had diagnoses which included end stage renal disease, vascular prosthetic device, anemia, cardiomegaly and hypertension. R54's order summary printed 9/17/25, indicated R54 had an order dated 8/28/25 for weight gain - call your provider if you gain 3 pounds or more overnight, or gain 5 pounds in a week. In addition, the order summary indicated an order for fluid restriction 32 ounces (oz) (960 milliliters) daily dated 8/27/25. On 9/16/2025 at 12:41p.m., R54 was observed in the dining room for lunch with an 8 ounce cup of coffee and an 8 ounce glass of water. Progress note dated 9/7/2025 at 1:31a.m., indicated R54 complained of shortness of breath and difficulty falling asleep. R54 was placed on oxygen.Progress note dated 9/8/25 at 6:41 a.m., indicated R54 complained of shortness of breath and requested oxygen. When interviewed on 9/16/2025 at 1:55 p.m., licensed practical nurse (LPN)-A stated R54 complained of a hard time breathing which started the day before going to dialysis. LPN-A was not sure R54 had parameters regarding weight gain. LPN-A stated dialysis nor the provider had been updated regarding R54 having complained of having a hard time breathing or weight gains. LPN-A stated dialysis would have been updated by documenting the weight gain on the communication form that was sent with R54 to dialysis. When interviewed on 9/16/2025 at 3:08 p.m., registered nurse (RN)-B stated R54 occasionally went over her fluid restriction, communication with dialysis center was done using the communication form that was sent with R54 to dialysis. When asked regarding location of where communication forms were placed in R54's medical record RN-B went to R54's room and returned with several envelopes with communication forms inside. RN-B stated the forms were to be reviewed by the nurse for concerns or communication from dialysis center then placed in a dialysis binder for R54 but was unable to locate a binder for R54, RN-B then stated the forms would get scanned into the resident electronic medical record (EMR). When communication forms were reviewed there was no indication dialysis was updated regarding weight gains or complaints of shortness of breath between dialysis days. On 9/17/2025 at 8:15 a.m., reviewed R54's fluid intake recorded in electronic medical record (EMR), there was no order located on R54's treatment sheets to record fluid intake for the month of August 2025. In September 2025 treatment sheet indicated nursing staff started recording fluid intake on 9/3/25. Order indicated fluid restriction 32 ounces.Day shift 9/4/25 - 9/16/25:9/4/25: 240 milliliters (ml)9/5/25: 240 ml9/6/25: 360 ml9/7/25: 240 ml9/8/25: 240 ml9/9/24:120 ml9/10/25: 240 ml 9/11/25: 360 ml9/12/25: 32oz9/13/25: 360 ml9/14/25: 360 ml9//15/25: 300mlEvening shift 9/3/25-9/16/25:9/3/25: .240 ml9/4/25: 220 ml9/5/25: 4oz9/6/25: 32 oz9/7/25: 120ml9/8/25: 240 m,9/9/25: 120ml9/10/25: 240 ml9/11/25: 240 ml9/12/25: 32 oz9/13/25: 240ml9/14/25: 360 ml9/15/25: 300 ml9/16/25: 240 mlNight shift 9/3/25-9/16/25:9/3/25: 2 oz9/4/25: 0 oz9/5/25: 3 oz9/6/25:120 ml9/7/25:100 ml9/8/25: 240 ml9/9/25: 120 ml9/10/25: 2 oz9/11/25: 0 oz9/12/25: 0 oz9/13/25: 60 ml9/14/25: 300 ml9/15/25: 0 oz9/16/25: 0 oz. Review of R54's meal fluid intake was reviewed 9/2/25 through 9/16/25, dietary fluid intakes were recorded by total for the day which included all three meals, intakes were recorded as:9/2/25: 1100 ml9/3/25: 360 ml9/4/25: 360 ml9/5/25: 540 l9/6/25: 1000 ml9/7/25: 540 ml9/8/25: 440 ml9/9/25: 320 ml9/10/25: 440 ml9/11/25: 600 ml9/12/25: 440 ml9/13/25: 790 ml9/14/25: 640 ml9/15/25 400 ml9/16/25: 700 ml.There was no order or indication of facility staff totaling the amount of fluid intake between what nursing staff were providing to R54 and the amount R54 was consuming at meals to ensure R54 was following fluid restrictions. Reviewed R54's EMR, two dialysis communication forms were located in R54's EMR. No other communication (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	09/17/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forms were located in R54's EMR. In addition, the care plan and face sheet in the EMR failed to indicate the location and contact information for R54's dialysis. When interviewed on 9/17/2025 at 9:37 a.m., licensed practical nurse (LPN)-A stated what was recorded on the treatment sheets was fluids nursing personally gave R54 with medications and occasionally what was noticed R54 consumed outside of meals. Dietary staff recorded what was provided from the kitchen staff during mealtime. When interviewed on 9/17/2025 at 1:15 p.m., registered dietician (RD) from dialysis center stated they spoke with facility dietician on 9/8/25 regarding 1R54's fluid restriction, received a supplement that needed to be counted towards the 1000 ml. RD was concerned R54's weight was low but her gains have been quite large. The weight gains were difficult to safely remove during dialysis, the fluid overload between runs could be related to her complaints of shortness of breath. During interview on 9/17/2025 at 1:31 p.m., culinary services director (CSD) stated they recently talked with RD at dialysis center regarding the supplement needed to be counted toward the fluid restriction. CSD just discussed with R54 what fluids were wanted at each meal and needed to figure out what nursing staff needed to use for medication passes as this also needed to count towards the fluid restriction. CSD stated after discussion with RD that the supplement was not included in the fluid restriction realized that R54's meal ticket did not specify how much fluid R54 was to have for each meal, they just updated R54's meal ticket to reflect what fluids with specific ounces were to be given to R54 at each meal. CSD stated the dietary aides were responsible to record fluid intake consumed during each meal. When interviewed on 9/17/2025 at 2:00 p.m., registered nurse (RN)-A stated R54 had a really low fluid restriction, nursing staff should combine all fluid intake for their shift in the EMR. RN-A stated working with CSD to adjust the fluid allowance between dietary and nursing, they just updated her meal tickets and nursing was reminded to only provide four ounces (120ml) at each medication pass. RN-A stated they completed a resident/family education form with R54 to discuss the fluid restriction. RN-A stated dialysis communication forms should be completed with morning weight, vital signs and any information that dialysis should be made aware of including but not limited to weight gains, complaints regarding shortness of breath, fluid restriction concerns. Communication forms may contain communication from dialysis to the facility, expectation was for the nurse to review the forms for any communication from dialysis and scan them into R54s EMR with twenty-four hours. Resident Family Education assessment dated [DATE], indicated discussed fluid restriction with R54. Education was provided on fluid restriction orders and concerns for kidney inability to process fluid and effect on dialysis. RD reviewing with resident, worked with dietary to manage fluid restriction between medication pass and meals. When interviewed on 9/17/2025 at 2:35 p.m., director of nursing (DON) stated fluid intake in the EMR should contain what nursing staff provided, what dietary provided and anything staff had observed R54 take it upon herself to consume. DON stated facility did not complete risks versus benefits with residents, rather facility completed a resident/family education assessment. Correct fluid intake documentation was important to help monitor resident intake when on fluid restriction. DON stated communication forms were to be completed with vital signs, weights and any other information dialysis needed to be made aware of. When resident returned from dialysis forms were expected to be reviewed, any information relayed by dialysis acted upon in needed, then scanned into the EMR. Any change in resident status for example, weight increase and shortness of breath was expected to be provided to the provider via phone call or fax to ensure consistent coordinated care to the resident. Facility Dialysis policy dated 11/22/19, indicated the facility staff and the dialysis center would have ongoing communication and collaboration regarding dialysis care and services. Communication shared between facility and dialysis center could include but not limited to, residents response to dialysis, medications administered, labs drawn, and changes in condition or mood. In addition, the policy indicated Documentation should include fluid innate amounts for each shift with a 24 hour total if a fluid restriction was in place.

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	09/17/2025

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 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. Based on observation and interview, the facility failed to ensure medications were stored and handled in accordance with professional standards of practice and facility policy. Specifically, staff pre-set multiple residents' medications into medication cups and stored them in the top drawer of the medication cart, creating a risk for medication errors, contamination, and administration of the wrong medication to residents. This deficient practice had the potential to affect 3 of 3 residents whose medications were observed in the cart.Findings include:During observation of the medication cart and interview with licensed practical nurse (LPN)-B on 9/15/25 at 3:48 p.m., the surveyor opened the top drawer of the cart and observed five plastic medication cups, each containing various crushed medications. The medication cups had resident initials and medication times written on them. The medications were sitting loosely in the drawer without protection from contamination or temperature control. LPN-B stated she had pre-set medications for several residents and placed the cups in the drawer to save time. LPN-B stated the cups were prepared approximately 30 minutes earlier and acknowledged they were not individually secured. LPN-B stated she had some extra time and was not familiar with this particular unit, so she pre-set all the scheduled medications beforehand. LPN-B stated she should not have pre-set medications, as doing so could lead to medication errors and administering medications to the wrong resident.During an interview on 9/16/25 at 12:36 p.m., LPN-C stated staff were not permitted to pre-set medications ahead of scheduled administration times and confirmed all medications must remain in their original, labeled packaging until they are administered directly to the resident. LPN-C stated that storing pre-set medications in the cart drawer was not acceptable practice and against policy.During an interview on 9/17/25 at 1:01 p.m., the assistant director of nursing (ADON) stated the facility's expectation medications must remain secured in their original pharmacy-labeled containers until administration. The ADON verified pre-setting medications and storing them in the cart drawer created an opportunity for medication errors and cross-contamination.During an interview with the director of nursing (DON) on 9/17/25 at 2:35 p.m., the DON stated medications should not be pre-set and doing so was against facility policy. The DON stated pre-setting medications could cause medication errors because staff would be unable to verify the residents' medications against the medication administration record and the physician orders.A medication storage policy was requested but was not received.