STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folkestone	100 Promenade Avenue Wayzata, MN 55391

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and document review, the facility failed to ensure confidential information was not readily available for all residents, staff, and visitors to view for 3 of 3 residents (R3, R16, and R21) who's confidential information was observed to be visible on the open computer screen in the hallway.Findings include:During a medication pass observation on 11/17/25 at 6:33 p.m., trained medical assistant (TMA)-A prepared R16's prescribed medication for administration. TMA-A locked the Salon medication cart, went to R16's room, closed the door, and gave R16 the prescribed medication. The computer screen on the Salon medication cart was left open to R16's confidential information. TMA-A went back to the Salon medication cart and charted the medication was given.During a medication pass observation on 11/17/25 at 6:38 p.m., TMA-A prepared R3's prescribed medication for administration. TMA-A locked the Salon medication cart, went to R3's room, closed the door, and gave R3 the prescribed medications. The computer screen on the Salon medication cart was left open to R3's confidential information. TMA-A went back to the Salon medication cart and charted the medication was given.During a medication pass observation on 11/17/25 at 6:45 p.m., TMA-A prepared R21's prescribed medication for administration. TMA-A locked the Salon medication cart, went to R21's room, closed the door, and gave R21 the prescribed medications. The computer screen on the Salon medication cart was left open to R21's confidential information. TMA-A went back to the Salon medication cart and charted the medication was given.During an interview on 11/17/25 at 6:53 p.m., TMA-A stated the computer screen was left open with the resident's confidential information on it. TMA-A stated the computer screen was not locked for the three residents. TMA-A stated the computer screen should have been locked so others could not read about the residents. During an interview on 11/20/25 at 2:50 p.m., clinical administrator (CA) there was a process for locking the computer screen so others could not view a resident's confidential information. CA stated the computer screen should have been locked when staff were not observing the computer screen. The facility policy Notice of Privacy Practices dated 7/21/21, indicated they were required by law to maintain the privacy of your health information.

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
	245621	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folkestone	100 Promenade Avenue Wayzata, MN 55391

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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 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. Based on observation, interview, and document review the facility failed to ensure a medication was secured in a resident accessible areas. This had the potential to affect all residents who received medications from the Salon medication cart.Findings include:During an observation on 11/17/25 at 6:33 p.m., trained medical assistant (TMA)-A prepared medication for administration to R16. TMA-A locked the Salon medication cart and left a bottle of acetaminophen 500 milligram (mg) tablets about half full sitting on top of the Salon medication cart in the hallway. TMA-A went into R16's room, closed the door, and gave R16 the prescribed medication.During an observation on 11/17/25 at 6:38 p.m., TMA-A prepared medication for administration to R3. TMA-A locked the Salon medication cart and left a bottle of acetaminophen 500 mg tablets about half full sitting on top of the Salon medication cart in the hallway. TMA-A went into R3's room, closed the door, and gave R3 the prescribed medication.During an interview on 11/17/25 at 6:43 p.m., TMA-A indicated she had left the bottle of acetaminophen 500 mg tablets half full sitting on top of the Salon medication cart while she had gone into resident's rooms and closed the doors to administer prescribed medications. TMA-A stated the bottle of acetaminophen 500 mg was not locked up in the Salon medication cart as it should have been. During an interview on 11/20/25 at 12:04 p.m., clinical administrator (CA) indicated we have a process for medication storage and the medication should be stored in the locked medication cart.The facility policy Medication Ordering and Receiving from Pharmacy undated, indicated except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area.