DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
May 5, 2022

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

RE: CCN: 245328
Cycle Start Date: February 17, 2022

Dear Administrator:

On March 9, 2022, we notified you a remedy was imposed. On March 21, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 18, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 24, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 9, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 24, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 18, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered
May 5, 2022

CMS Certification Number (CCN): 245328

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 18, 2022 the above facility is certified for:

91 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 91 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically Submitted
March 9, 2022

Administrator
Parmly On The Lake LLC
28210 Old Towne Road
Chisago City, MN 55013

RE: CCN: 245328
Cycle Start Date: February 17, 2022

Dear Administrator:

On February 17, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 15, 2022, the situation of immediate jeopardy to potential health and safety cited at F760 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 24, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 24, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 24, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Parmly On The Lake LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 17, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 17, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing

Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145

St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245328 | A. BUILDING _____ B. WING _____ | C 02/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARMLY ON THE LAKE LLC | 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 2/14/22 through 2/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>Revised 2567 as a result of an Informal Dispute Resolution<br>On 2/14/22 through 2/17/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F760. The IJ began on 2/10/22, when the facility failed to obtain an INR (international normalized ratio -a blood test to determine blood clotting time) which resulted in R54 not receiving Coumadin (a blood thinner) daily 2/10/22 to 2/14/22. This had the potential to cause serious harm or death to R54 who had a recent history of pulmonary embolism (blood clot in the lung). The administrator and director of nursing (DON) were notified of the IJ on 2/15/22, at 12:51 and the immediacy was removed on 2/15/22.<br><br>The above findings constituted substandard | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/14/2022 |

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.

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| F 000 | Continued From page 1<br>quality of care, and an extended survey was conducted from 2/16/22 to 2/17/22.<br><br>The following complaint was found to be SUBSTANTIATED: H5328055C (MN79293), with a deficiency cited at F760.<br><br>The following complaints were found to be UNSUBSTANTIATED: H5328053C (MN80677 and MN80930), H5328054C (MN80014), and H5328056C (MN79097).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. | F 578 | | 3/18/22 |

| 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 578 | Continued From page 2<br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to ensure the medical record showed documentation of a current advanced directive, applicable to the State of Minnesota, and the resident's chosen healthcare decision-maker for 1 of 3 (R3) residents reviewed for advanced directives.<br><br>Findings included: | F 578 | F578 Advanced Directives<br>R3□s advanced directives have been reviewed and the facility social services team is working with the resident and care team to fulfill resident□s wishes.<br>A review of all resident□s advanced directives was initiated and resident□s advanced directives will be reflected in their medical record. | |

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| F 578 | Continued From page 3<br><br>R3 was admitted to the facility in April 2021, with diagnoses that included diabetes, persistent mood disorders, chronic kidney disease, Schizophrenia (a long-term mental disorder involving the breakdown in the relation between thought, emotion, and behaviors), and was on palliative care.<br><br>R3' care plan, initiated on 4/23/21, identified that R3 was a "DNR (Do Not Resuscitate)"<br><br>R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/09/21, revealed a Basic Interview of Mental Status (BIMS) of 13 out of 15 which indicated he was cognitively intact for daily decision-making and was now on hospice care.<br><br>R3's Advanced Directive from the State of Wisconsin that R3 signed on 7/08/09, indicated on the Advanced Directive that his Power of Attorney for Health Care (POAHC) would be Family Member (FM)-B. FM-D was listed as an alternate agent, however FM-D did not sign the document.<br><br>R3's POA, dated 11/20/12, indicated that R3 indicated his Attorney-in-fact would be FM-B. The POA paperwork further revealed, ...This Power of Attorney shall not take effect until such time as the principal indicates in writing that he wishes it to take effect, or two physicians or a physician and psychologist who have personally examined him sign a statement that specifically expresses their opinion that he as a condition that means that he is unable to receive and evaluate information effectively or to communicate decision to such an extent that he lacks the | F 578 | The Advanced Directives Policy was reviewed and remains accurate.<br>Education was initiated with members of the social services department in regards the Advanced Directive policy.<br>Advanced Directives will be reviewed with each new resident upon admission and then quarterly with each resident during care conferences, if applicable.<br>The Director of Nursing or designee will conduct weekly audits x4 weeks and monthly x2 months to review the IDT care conference summaries to ensure the advanced directive review was completed and documented.<br>The QAPI committee will review the results of the audits to determine whether the plan of correction was effective or if continuous monitoring and system changes need to be implemented. | |

| 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 578 | Continued From page 4<br>capacity to manage his financial decisions ...<br><br>A Physician's Evaluations of Resident's Capacity to Make Health Care Decisions or Provide Informed Consent, dated 4/24/18, showed that only one physician signed that R3 was incapacitated to make health care decisions.<br><br>Review of a POA form, from the State of Florida, signed by R3 on 10/01/19, revoked any previous power of attorney granted by R3. R3 granted FM-C as his agent in the document, FM-D was not granted authority.<br><br>The Do Not Resuscitate Order, from the State of Florida, dated 3/26/21, showed that FM-D signed the DNR order for R3 and indicated he had durable power of attorney.<br><br>Review of the POLST (Physician Orders for Life-Sustaining Treatment), dated 4/21/21, showed FM-D signed the form as R3's POA. He indicated that R3 was a DNR with comfort-based treatment only.<br><br>In an interview on 2/24/22, at 1:10 p.m, R3 stated he was aware that he was dying and did not want his son as his POA. He stated he wanted to talk to "someone" regarding his burial arrangements, but no one has spoken to him.<br><br>In an interview on 2/15/22, at 3:40 p.m, Social Service Director (SSD) stated that R3 has a POAHC from the State of Florida and there was a letter of incapacitation also on the form. The SSD stated that she had spoken to R3 many times about his burial plans, dying and his concerns that he does not want to die alone. The SSD further stated that the hospice chaplain was | F 578 | | |

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| F 578 | Continued From page 5 | F 578 | | |

very involved. The SSD was asked if R3 had been asked to sign a State of Minnesota POA for health care. She stated she had not spoken to the resident regarding this.

In a follow-up interview on 2/16/22, at 10:30 a.m., the SSD was asked if she had based her assessments of R3 on the incapacitation letter from 2018. She stated yes. She was asked if she had discussed with R3 his wishes to be a DNR as his BIMS score indicated that he was cognitive intact to make decisions. She stated no. The SSD further stated that she had reached out the Ombudsman and the Elder Justice Center on 1/10/22, for more assistance.
In an interview on 2/16/22, at 2:39 p.m., the Ombudsman stated that she met with R3 about a week ago at the facility. She stated that she was working on his "wants" and needs at this time regarding his POA. The Ombudsman stated that R3 did not want his son making decisions for him and that R3 was his own decision-maker. The Ombudsman stated the resident has a right to revoke his son however, the facility should have put together paperwork from the State of Minnesota as R3 was able to make his own decisions.

Review of an undated facility policy titled, "Health Care Directives, revealed, ... we recognize that our residents have the right to direct the course of their care in our Care and Rehabilitation Center and may choose not to receive some treatment that is customarily provided to our residents under our standing orders or working protocols, even if the treatment is potentially life-prolonging ...The facility in cooperation with the primary physician must ensure that any proxy seeking to authorize limitation of treatment or services on

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| F 578 | Continued From page 6<br>behalf of the resident makes that authorization in a manner consistent with law, good medical practice, and professional ethics. We believe the resident must be involved in the decision-making process to the fullest extent the resident is able to do so .. | F 578 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by: | F 657 | | 3/18/22 |

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| F 657 | Continued From page 7<br>Based on interview and document review, the facility failed to ensure a resident's care plan was revised for 1 of 3 residents (R25) reviewed for weight loss, creating the potential for the resident to continue to experience unplanned weight loss.<br><br>Findings include:<br><br>Review of R25's Admission Record, revealed she was admitted to the facility on 2/19/21, with diagnoses that included Parkinson's disease, post-polio syndrome, muscle wasting, vitamin B12 deficiency anemia, dysphagia, severe protein calorie malnutrition, major depressive disorder, and anxiety.<br><br>Review of R25's care plan dated 2/25/21, revealed the resident had a Focus of Potential for alteration in nutrition r/t (related to) need for nursing home placement secondary to dx (diagnosis) of: Parkinson's, anxiety, GERD (Gastroesophageal Reflux Disease), respiratory failure, dysphagia, depression, severe protein calorie malnutrition. Mechanically altered diet r/t dysphagia. Further review of the care plan revealed a nutritional intervention okay to have soft cookies/cookies soaked in a little milk, beginning on 4/27/21.<br><br>Registered Dietician (RD) progress notes dated 5/05/21, at 11:13 a.m., ...Weight Warning. Value 154.5 (pounds). -5.2% (in thirty days). Resident triggered for significant weight loss ... Resident is eating well, consuming 76-100% of meals. Current weight is 154.5# (pounds), 162.9# 1 month ago ... Weight loss of 8.4# noted in one month. Resident has a hx (history) of tube feeding and severe protein calorie malnutrition. UBW (Usual Body Weight) is around 159-163# | F 657 | F657 Care Plan Timing and Revision<br>R25's care plan has been reviewed and updated to reflect resident's weight loss and interventions.<br>Like residents who have had weight loss have had their care plans reviewed and updated.<br>The Registered Dietician and Culinary Director will receive education on updating care plans for alterations resident's weights/weight loss.<br>The weekly IDT meetings focused on nutrition and intakes will continue and care plan updating will be added as s focus of this meeting.<br>DON or Designee will complete audits weekly x4 then monthly x2. Audit results will be reviewed by QAPI Committee for further recommendations. | |

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| F 657 | Continued From page 8<br>per resident. D/t [due to] great intake, diet upgrade to mechanical soft, and BMI (Body Mass Index - a calculation of weight in relation to height, normally 18.5 - 25) of 29.3, continue POC (plan of care). Recommend to monitor appetite/intake/weight status for potential nutritional supplement need ...<br><br>RD's progress notes dated 7/13/21, at 11:46 a.m., ... Weight Warning. Resident triggered for significant weight loss ... Resident is eating well, consuming 51-100% of meals. Current weight is 150.1#, 151.3# 1 month ago, 162.9# 3 months ago ... Weight loss of 1.2# in 1 month and 11.7# in 6 months ... Resident reports that she feels good at her current weight and thinks she is eating enough food at meals. Resident is open to receiving a nutritional supplement, if necessary D/T [due to] good intake and BMI of 29.3, continue POC [plan of care] ... Continued review of the note did not reveal why R25's care plan was not revised with new interventions to help her maintain her body weight, as she expressed contentment with that weight and was losing weight with her current care plan.<br><br>RD progress notes on 8/11/21, at 10:01 a.m. ... Weight Warning. Resident triggered for significant weight loss ... consuming 51-100% of meals. Current weight is 146.9#, 151.1# 1 month ago, 156# 3 months ago, and 161.8# at admission ... Weight loss of 4.2# in 1 month and 14.9# in 6 months ... continue POC ... Continued review of the note revealed no new interventions to prevent further weight loss or updates to the care plan.<br><br>Review of R25's care plan dated 11/18/21, revealed her nutritional interventions were modified to include, Diet: regular diet, mechanical | F 657 | | |

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| F 657 | Continued From page 9<br>soft with puree meats, thin liquids.<br><br>Interview with the RD on 2/16/22, at 9:48 a.m. revealed, At one point, I realized her (R25's) weight loss was too severe - out of control, and at that point we started intervening. I added a nutritional supplement, then changed it to Thrive ice cream because she said that was what she wanted. She was eating that pretty well, according to the MAR (Medication Administration Record). The RD stated the facility did not have an established plan for more frequent reviews to monitor the effectiveness of their care plan interventions or modify them sooner that when the resident "triggered" for further weight loss.<br><br>The director of nursing (DON) was interviewed on 2/17/22, at 1:43 p.m. If the resident desired weight loss there should have been a specific goal and care plan approaches developed to ensure the weight loss occurred in a controlled and healthy manner; or that if a resident continued to lose weight there should be interventions to maintain her weight at the identified goal.<br><br>Review of the facility's policy titled "Care Planning," revised 1/06/22, provided by the facility, revealed Comprehensive Care Plan ...The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful 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. | F 657 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI | F 690 | | 3/18/22 |

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| F 690 | Continued From page 10<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document | F 690 | F690 Bowel/Bladder Incontinence, | |

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| F 690 | Continued From page 11<br>review, the facility failed to ensure a resident with an indwelling urinary catheter had updated interventions and received care and services to prevent excessive tension on the catheter which led to urethral trauma for 1 of 2 (R38) residents reviewed for catheters.<br><br>Findings include:<br><br>Review of the facility's policy titled Catheter Care, Urinary, revised September 2014, revealed The purpose of this procedure is to prevent catheter-associated urinary tract infections ...Changing Catheters ...2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh).<br><br>Review of R38's Face Sheet, revealed R38 was admitted to the facility on 1/05/22, with diagnoses that included obstructive and reflux uropathy unspecified, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, and retention of urine unspecified.<br><br>Review of R38's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/11/22, revealed R38 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed R38 had an indwelling catheter and intermittent catheterization.<br><br>Review of R38's care plan was initiated on 1/06/22, and revised on 1/27/22 identified alteration in elimination AEB [as evidenced by] urinary retention requiring frequent PVR [post void residual] every 6 hours. Risk factors include | F 690 | Catheter, UTI<br>R38 has been discharged<br>All like residents who have been identified for catheter use have had their care plan reviewed to ensure a device is applied to their leg to assist in preventing trauma.<br>The DON or designee will initiate education to all appropriate staff to ensure a device is applied to their leg to assist in preventing trauma.<br>The DON or designee will complete audits weekly x4 and then monthly x2. Audit results will be reviewed by QAPI Committee for further recommendations. | |

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| F 690 | Continued From page 12 | F 690 | | |

BPH, anemia, HTN [hypertension], HF [heart failure], DM II [diabetes mellitus], impaired mobility d/t [due to] hemiparesis/hemiplegia. Assistance with toileting and peri care needs. The care plan also indicated the intervention Foley catheter care per policy. However, the care plan was not revised with interventions to prevent urethral trauma or further trauma to R38's penis.

Review of R38's Northside Nurse Aide Care Plan, undated, revealed R38 had catheter irritation at tip of penis. Assure stat lock in place and catheter is not pulling. Alert nurse of open areas or bleeding. However, the care plan did not indicate R38 had a catheter, to provide indwelling urinary catheter care every shift, and to ensure the catheter was appropriately secured to the R38's leg to prevent urethral trauma.

Review of R38's Physician's Orders, dated 1/08/22, revealed Place catheter - change catheter monthly with 16 French Coude catheter every evening shift every 28 day(s).

Review of R38's Weekly Skin Inspection, dated 1/23/22, revealed pt [Patient] has water filled sac noted to rim of penis. to the right side of meatus there is a 0.5 x [by] 0.5 cm [centimeter] area that is discolored dark purple, red and irritated, Bacitracin [a topical antibiotic] applied and NP [nurse practitioner] updated.

Review of R38's Physician's Orders, dated 1/24/22, revealed Remove Foley catheter for voiding trial. Voiding trial x [for] 3 days. Assess voiding every 6 hours with bladder scan or history. Start straight catheter PRN [as needed] if > [greater than] 400 ml [milliliters] residual.

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| F 690 | Continued From page 13 | F 690 | | |

Review of R38's Physician's Orders, dated 1/28/22, revealed Assess voiding every 6 hours with bladder scan or history. Start straight cath [catheter] prior if > [greater than] 400 ml [milliliters] residual. Every 6 hours related to benign prostatic hyperplasia [BPH] with lower urinary tract symptoms until 1/31/22.

Review of R38's Weekly Skin Inspection, dated 1/28/22, revealed scab to tip of penis proximal to urethral meatus measuring 0.2 x 0.5 cm [centimeters] with surrounding redness measuring 1 x [by] 1 cm [centimeters].

Review of R38's Weekly Skin Inspection, dated 2/04/22, revealed Urethral erosion present from indwelling catheter, catheter/peri cares preformed (sic) daily.

Review of R38's Physician's Orders, dated 2/01/22, revealed Place catheter - change catheter monthly with 16 French Coude catheter every evening shift every 28 day(s).

Review of R38's Weekly Skin Inspection, dated 2/11/22, revealed Urethral erosion present from indwelling catheter, catheter/peri cares preformed (sic) daily and PRN [as needed]. Bacitracin [a topical antibiotic] applied to urethral erosion after shower. Protective cream to pink tender to touch scrotum. Penis blister deflated.

Interview on 2/16/22, at 12:55 p.m. with registered nurse (RN)-B revealed R38 was transferred to the Northside unit last week while she was on vacation, and she didn't know he had a urethral tear and erosion until inquiry. RN-B stated she observed the urethral tear and erosion to R38's penis in the bathroom at 10:00 a.m. and

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| F 690 | Continued From page 14<br>determined that the StatLock (strap free device which locks the indwelling catheter in place, stabilizes the catheter and eliminates any chance of a sudden pull) was secured to his lower thigh and there wasn't any slack in the tubing which applied pressure to the urethra and could have caused the urethral tear and erosion. RN-B stated she moved the StatLock to R38's upper thigh to prevent further injury to his urethra. RN- B stated the nursing care plan was not revised when the urethral erosion was identified by the nurse on the other unit and the nurse aide care plan wasn't revised to prevent further trauma until she revised it after her observation.<br><br>Observation on 2/17/22, at 8:24 a.m. of R38's indwelling catheter with RN- B revealed the catheter was secured to the R38's right upper thigh. Continued observation revealed scant bleeding from the meatus, and a tear and slough to the distal meatus. Interview with RN-B at this time revealed her observation on 2/16/22, revealed R38's penis was pressing against his left upper thigh because the tubing was stretched too tight and the StatLock was secured to R38's lower thigh so she moved to it R38's right upper thigh so prevent it causing further injury. Interview with R38 at time of observation along with RN-B revealed prior to RN- B moving the catheter tubing yesterday, he could feel the catheter tubing pulling but he didn't know he was bleeding or had an injury. R38 also stated that the nurse aides provided catheter care daily, but they were securing the tubing too tight.<br><br>Interview on 2/17/22, at 9:21 AM with RN-C revealed R38 was admitted to her unit when the catheter was placed on 1/08/22, the urethral trauma to R38's penis was identified on 1/23/22, | F 690 | | |

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| F 690 | Continued From page 15<br>and it was treated per the nurse practitioner's orders. RN-C stated the nurse aides provided catheter cares every shift and the R38 had a StatLock to prevent urethral tension, but there was no documented evidence that cares were provided and the StatLock was applied correctly to R38's leg.<br><br>Interview with 2/17/22 at 9:46 a.m. with the director of nursing (DON) revealed it was her expectation that residents with indwelling catheters had a device applied to their leg correctly to prevent trauma per the catheter care policy. | F 690 | | |
| F 760 SS=J | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure an International Normalized Ratio (INR a standard lab test used when taking blood-thinning medications) was obtained per physician order and the facility failed to administer Coumadin (a blood-thinning medication) per the INR level for four days for 1 of 7 (R54) residents reviewed for Coumadin use. This caused a delay in care and treatment and resulted in an immediate jeopardy (IJ) for R54. In addition, the facility failed to administer an antibiotic medication for 12 days, prior to being identified by the physician, for 1 of 15 (R35) residents, on antibiotic therapy.<br><br>The IJ began on 2/10/22, when nursing staff | F 760 | F760 Residents are free of significant errors<br>R35 has been discharged.<br>R54 INR orders have been received and obtained through Anticoagulation clinic.<br>R54 plan of care and orders have been reviewed and updated.<br>Like residents who have been identified for having INR orders and antibiotic orders have had their orders reviewed and updated per physician orders or anticoagulation clinic orders. Like residents have had their care plans reviewed and updated.<br>The DON or designee will initiate education to all appropriate staff on the | 3/18/22 |

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| F 760 | Continued From page 16<br>failed to obtain an INR and did not administer Coumadin for four days to R54. R54 had history of pulmonary embolism(PE -blood clots in the lung) and was at increased risk of serious harm and/or death. The Administrator and director of nursing (DON) were notified on 2/15/22 at 12:51 p.m. and the IJ was removed on 02/15/22, when the facility's approved removal plan was verified onsite by the state agency (SA).<br><br>Findings included:<br><br>R54 was admitted to the facility on 1/24/22, with diagnoses that included a history of bilateral pulmonary embolisms, bacterial pneumonia, irregular heart rhythm, and respiratory failure.<br><br>Review of a hospital Physician Progress Note, dated 1/23/22, revealed R54 had been diagnosed on 7/18/21, with two possible pulmonary embolisms's located on the left upper and lower lobes of her lung and had been on anticoagulant therapy since that time, and would need to continue the medication with close monitoring of the INR. The notes identified R54 had an INR level of 2.77 (normal range for an INR is 2.0-3.0) and her Coumadin dose was 2.5 milligrams (mg) once daily at 6:00 p.m..<br><br>R54's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/31/22, listed R54 had moderately impaired cognition for daily decision-making and had been administered an anticoagulant medication for seven out of seven days during the assessment period.<br><br>Review of the facility's Anticoagulation Flow sheet, revealed after R54 was admitted to the | F 760 | process of transcribing and implementing provider orders.<br>The DON or designee will complete audits weekly x4 and then monthly x2. Audit results will be reviewed by QAPI Committee for further recommendations. | |

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| | 245328 | A. BUILDING _____ B. WING _____ | C 02/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PARMLY ON THE LAKE LLC | 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013 |

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| F 760 | Continued From page 17 | F 760 | | |

facility, an INR was obtained on 1/28/22. The INR level was 1.6 (below the recommended therapeutic level of 2.0 to 3.0) The provider was notified. The provider ordered: Coumadin 7.5 mg today and 2.5 mg on Saturday, and 5 mg on Sunday. Staff were to recheck the INR on 1/31/22.

On 1/31/22, the INR was obtained which showed a level of 2.3. The provider was notified and the new order given for Coumadin 2.5 mg today, 5 mg on 02/01/22, 2.5 mg on 2/03/22. Staff were to redraw an INR on 2/03/22.

On 2/03/22, the INR was obtained which showed a level of 2.1. The provider was notified, the new order for Coumadin was 2.5 mg on Monday, Wednesday, and Saturday and 5 mg all the other days. Staff were to redraw the INR on 2/10/22.

The Anticoagulation Flow sheet did not list documentation of an INR drawn on 2/10/22. Therefore there were no orders for Coumadin from 2/10/22 to 2/14/22 (four days).

On 2/14/22, an INR was obtained which showed 1.2 (therapeutic range for R54 was 2.0 to 3.0) and a note which showed, "drawn per medical director." The new order read to give Coumadin 5 mg today and a recheck of the INR was for 2/15/22.

A review of the February 2022 Medication Administration Record (MAR) showed no documentation Coumadin had been given between 2/10/22 and 2/14/22.

A care plan for the use of anticoagulant medication was not created prior to 2/15/22,

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| F 760 | Continued From page 18 | F 760 | | |

however, R54's care plan was developed on 2/15/22, for potential for alteration in blood formation and coagulation, related to use of anticoagulant medication due to history of PE, staff were to administer anticoagulant medication as ordered by the provider and to monitor labs, as ordered.

In an interview on 2/15/22, at 8:19 a.m., registered nurse (RN)-A, stated that INR's were done on the night shift, early in the morning. Each resident on Coumadin had a flow sheet, which was then handed off to the day shift in order to obtain orders from the provider. RN-A stated, "I don't know why" [R54's] INR was not done on 2/10/22." RN-A stated R54's INR should have been entered into the system, the night shift would have done the INR and the day shift would have call the provider to obtain orders.

Provider Progress Notes, dated 2/07/22, identified nurse practitioner (NP)-B saw R54 for an "episodic" visit. NP-B documented R54's hospital course was long and complicated, and she remained very weak. In addition, R54 had a history of pulmonary embolus (PE) and was on long-term current use of anticoagulant therapy. R54 was on Coumadin, as directed by the Anticoagulation Clinic based on the INR. Her current dose of Coumadin was 2.5 mg on Tuesday, Friday, and Sunday, all other days she was on 5 mg daily. NP-B further documented "due for INR recheck 2/9/22". R54's medical record review revealed no actual order was written.

In an interview on 2/15/22, at 8:31 a.m., the DON stated she looked at the Anticoagulation Flow Sheet for the whole facility and found the INR for

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R54 had not been obtained on 2/10/22, and called the Medical Director to get orders. The DON stated the process was for night shift to obtain the INR, day shift to obtain provider orders, and the evening shift would administer the medication. The DON stated what happened for R54 was the recheck on the flow sheet documented 2/10/22, however, the rounding provider had ordered the INR for 2/09/22, but that was not documented on the flow sheet nor entered into the system.

The DON verified that R54 had gone four days without having had an INR obtained or Coumadin administered was at risk because R54 had a history of pulmonary embolisms.

In an interview on 2/15/22, at 11:48 a.m., the Medical Director (MD) stated when the DON called him on 2/14/22, that was the first he was made aware that R54 had not received Coumadin for four days. The MD stated NP-B saw R54 on 2/07/22, had written a note to obtain an INR on 2/09/22, however, she did not actually write an order. When the unit clerk saw the progress notes, she discontinued the INR for 2/10/22, but "technically, there was no order written."

The Medical Director stated the expected range for R54's INR was between 2.0-3.0. The MD stated a potential risk for not receiving Coumadin for four days would be the INR would go down and her risk increased for a stroke. The MD further stated that R54 also had an irregular heart rhythm which placed her at "high risk" for a stroke or PE.

The facility's Medication Errors policy dated January 2020 indicated the relative significance of

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medication errors was a matter of professional judgment. The resident's condition was an important factor to take into consideration. If the resident's condition requires rigid control, a single missed or wrong dose could be highly significant. The policy further indicated if the medication was from a category that usually required the resident to be titrated (measuring to a certain level) to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This was especially important with a medication that has a Narrow Therapeutic Index (NTI). Finally, the frequency of error is important; if an error was occurring repeatedly, there may be more reason to classify the error as significant. For example, if a resident's medication was omitted several times, it may be appropriate, depending on consideration of resident condition and medication category, to classify, that error as significant.

R35
Review of R35's Face Sheet, revealed R35 was admitted to the facility on 10/15/21, with diagnoses that included disseminated cryptococcosis disease (invasive fungus, transmitted through the inhalation of spores). R35 discharged to the community on 2/06/22.

Review of R35's Significant Change in Status MDS with an ARD of 1/05/22, found R35 had a BIMS score 13 of 15, which indicated the resident was cognitively intact. The MDS also indicated the resident had not received any antibiotics in the 7-day look back period.

Review of R35's Physician's Orders, dated 10/19/2, revealed Fluconazole (is used to prevent

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| F 760 | Continued From page 21<br>and treat a variety of fungal and yeast infections) tablet 200 mg give two tablets by mouth one time a day related to disseminated cryptococcosis until 12/01/21.<br><br>Review of R35's Infectious Disease Physician's Progress Notes, dated 11/24/21, revealed Continue Fluconazole 400 mg daily maintenance dose. Duration maintenance dose for at least 6-12 months...<br><br>Review of R35's Medication Administration Record (MAR), dated December 2021, revealed R35 did not receive Fluconazole 400 mg from 12/02/21 through 12/13/21.<br><br>Review of R35's Physician's Orders, start date 12/14/21 and discontinued date 02/06/22, revealed Fluconazole tablet 200 mg give 400 mg by mouth one time a day related to disseminated cryptococcosis.<br><br>Review of R35's Nurse's Note, dated 12/13/21, revealed Per 11/24[/21] visit with (infectious disease) [provider], Fluconazole [antifungal] 400 mg to continue indefinitely. Prior order had been entered with a stop date of 12/1. Medication fell off of active orders and has not been given since 12/1. Message left for [infectious disease physician] for further instruction ... Fluconazole 400 mg reinstated at this time per [Medical Director], and prior written instruction on after visit summary from 11/24.<br><br>Review of R35's Nurse's Note, dated 12/13/21, revealed Missed Fluconazole [antifungal] 400 mg [milligrams] 12-2 to 12-13. Consult with [Medical Director] and [infectious disease physician]. Continue Fluconazole [antifungal] 400 mg | F 760 | | |

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| F 760 | Continued From page 22<br>[milligrams] daily through next appointment with ID [infectious disease] in January ...<br><br>Review of R35's Nurse's Note, dated 12/13/21, revealed Resident and daughter, notified of resident not receiving Fluconazole [antifungal] between 12-1 and 12-13 and circumstances explained. Also updated on consult with [Medical Director] and [infectious disease physician] and decision to continue Fluconazole [antifungal] 400 mg [milligrams] QD [daily] through next ID [infectious disease] appointment. They have no further questions or concerns at this time.<br><br>Review of the Facility's Initial Incident Report, dated 12/13/21, provided by the facility, revealed, On 11/24/21, resident had a phone call visit with Infectious Disease and infectious disease ordered for Fluconazole [antifungal] 400 mg [milligrams] daily indefinitely for now for disseminated cryptococcal disease. At that time Nurse Manager looked at order that was in EMAR [electronic Medication Administration Record] and identified Fluconazole [antifungal] 400 mg [milligrams] was present. Nurse did not observe an end date to the medication, but it [the medication] did have an end date of 12/1/21 ...On 12/13/21 Medical Director rounded and noticed that Fluconazole [antifungal] was not in current medication list as ordered. Medical Director restarted Fluconazole [antifungal] and Nurse Manager notified Infectious Disease and they ordered it to be restarted as well ...No side effects were identified due to this medication not being administered. Resident to follow up with infectious disease in January. Investigation Initiated.<br><br>Interview on 2/14/22, at 12:02 p.m. with the | F 760 | | |

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Medical Director revealed he rounded in the facility on 12/13/21, and found R35's antifungal medication was not on the medication list as ordered so he restarted the medication. The Medical Director stated that he discussed the medication error with RN- B and told her to report the significant medication error to the State Agency (SA).

Interview on 2/16/22, at 10:45 AM with RN- B revealed R35 had a phone visit with the infectious disease provider and Fluconazole (antifungal) was ordered for six to twelve months. RN-B stated that after R35's phone visit with the infectious disease provider, she called the provider about the orders in the progress note but didn't request an order from the provider since R35 was already taking the medication at the same dosage. RN-B stated she reviewed the order, but she didn't observe the end date on the order of 12/01/21. RN-B stated that the Medical Director identified the medication was missing from R35's medication list on 12/13/21. RN- B stated that she notified the DON about the medication error on 12/13/21, and that she was educated on the medication administration policy on 12/13/21. RN-B stated that all orders will be entered as a new order, another nurse will verify the order, and the start and stop dates will be verified.

Interview on 2/16/22, at 11:06 a.m. with the DON revealed RN-B notified her on 12/13/21, of the medication error, she contacted the Medical Director, and the infectious disease Physician then restarted the medication for R35. The DON stated that she completed a medication error form, educated RN- B to check the end dates on all orders, then reviewed the medication

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administration policy with her. The DON indicated training with all nursing staff related to the medication administration policy was initiated with all nursing staff on 12/13/21. The DON stated the Health Information Care Coordinator (HICC) would enter the new orders, then the nurse or RN manager would verify/confirm order. The DON also stated the Infection Preventionist (IP) would audit the antibiotic orders now and antibiotic orders would be discussed in stand-up meetings.

Interview on 2/16/22, at 1:57 p.m. with the Infectious Disease (ID) Physician revealed that R35 was admitted to the facility after a complicated hospital stay and treatment for disseminated cryptococcosis disease. The ID Physician stated that she ordered Fluconazole 400 milligrams (mg) until 12/01/21, to prevent recurrence of the disease. The ID Physician also stated that she had a phone visit with R35 on 11/24/21, and ordered Fluconazole 400 milligrams (mg) for six to 12 months to prevent recurrence of the disease. The IP Physician indicated the facility notified her that R35 had missed 12 doses of the antifungal medication.

Review of the facility's policy titled "Medication Orders," dated August 2019, provided by the facility, revealed ..E. Documentation of the Medication Order...2) The following steps are initiated to complete documentation and receive the medications: a. Clarify the order. b. Call, fax, or electronically transfer the medication order to the provider pharmacy. c. Transcribe newly prescribed medications on the MAR or TAR/electronic medical record. When a new order changes the dosage of a previously prescribed medication, discontinue the previous entry by writing "Dc'd" and the date and

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| F 760 | Continued From page 25<br>highlighting the entry in yellow. Enter the new order on the MAR/TAR/electronic medical record. d. After completion, document each medication order entered on the appropriate form with date, time, and signature.<br><br>The IJ began on 2/10/22, and was removed on 2/15/22, when the facility received physician orders through the Anticoagulation Clinic and R54's plan of care and orders were reviewed and updated. Facility reviewed and updated their current INR Process to ensure INR's and Coumadin dosages were not missed. Facility educated appropriate staff on the protocol for physician INR orders and having correct Coumadin dosing. Audits will be conducted by the DON or designee to ensure INR's were completed and Coumadin medicaion was given as ordered. Interviews were conducted with nursing staff on 2/16/22, between 8:30 a.m. and 10:30 a.m. to verify the above plan was in place on 2/15/22. | F 760 | | |

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| | 245328 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/15/2022** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/15/2022. At the time of this survey, Parmly on the Lake was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/14/2022

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.

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Parmly on the Lake is a 1-story building with a no basement constructed in 1972 and is a Type II(111) with an addition, in 1999, construction Type II(111). In 2007 a 2-story building with no basement was added that was determined to be of Type II(111) construction. The upper floor has 12 resident rooms, and the lower level has a pool and therapy functions. There are two assisted living buildings that are connected to the building that are properly fire separated. The facility was inspected as one building. | K 000 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PARMLY ON THE LAKE LLC** | **28210 OLD TOWNE ROAD**<br>**CHISAGO CITY, MN 55013** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 2<br><br>The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 91 beds and had a census of 72 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 321 SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.<br>When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.<br>Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons) | K 321 | | 3/18/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245328 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/15/2022** |

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| K 321 | Continued From page 3<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a hazardous room per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 8.4. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/15/2022 at 10:45 AM, it was revealed by observation the room adjoining the break is not properly separated and is currently being used as a hazardous combustible storage room.<br><br>An interview with the Administrator and Environmental Services Director verified these deficient findings at the time of discovery. | K 321 | K321 Hazardous Areas - Enclosures<br>The combustible storage was removed from the room adjoining the break room area.<br>The walls in that room adjoining the break room are scheduled to be properly separated by dry wall. No storage will occur in that room until that work is completed.<br>All other storage areas were identified and audited to ensure proper fire protections are in place.<br>The QAPI committee will review the results of the audit to determine whether the plan of correction was effective or if continuous monitoring and system changes need to be implemented. | |
| K 372 SS=E | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke | K 372 | | 3/18/22 |

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| K 372 | Continued From page 4<br>barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain two smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1) On 02/15/2022 at 11:45 AM, it was revealed by observation by room C4 there is a 4" penetration above the doors in the corridor.<br><br>2) On 02/15/2022 at 12:15 PM, it was revealed by observation by room 187 there is a 5" penetration above the doors in the corridor.<br><br>An interview with the Administrator and Environmental Services Director verified these deficient findings at the time of discovery. | K 372 | K372 Building Spaces – Smoke Barriers<br>The smoke barriers by room C4 and room #187 have been repaired so no penetrations exist.<br>All other smoke barriers were audited and corrected if applicable, to ensure no penetrations exit.<br>An above ceiling work agreement was established and implemented to ensure all external contractors are aware of the requirements if needing to do work in and around the smoke barriers.<br>A quarterly audit was established in the preventative maintenance system to ensure all smoke barriers are checked for penetrations quarterly.<br>The QAPI committee will review the results of the audits to determine whether the plan of correction was effective or if continuous monitoring and system changes need to be implemented. | |