Electronically Delivered

April 30, 2025

Licensee
Parmly on the Lake
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL20872016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE	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) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20872016-0 On March 31, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 49 residents; 49 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license issued on August 1, 2024, through July 31, 2025. The ALFDC was located in a large building that also contained a separate licensed skilled nursing facility (SNF) and short stay rehabilitation unit. The ALFDC is in three separate units of the large building, one unsecured unit with a total of 24 apartments, and two (2) secured units one that contained nine (9) apartments and the other contained 16 apartments. On March 31, 2025, at 11:00 a.m., during the	0 110		

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0 110	Continued From page 2 entrance conference, regional director (RD)-B stated the licensed assisted living director (LALD) of record should be health service executive (HSE)-J, but she will need to check on this and get back to me. RD-B also stated acting administrator temporary permit (AATP)-E was going to take over as the LALD of record for the ALFDC after she was completed with her training program. On April 1, 2025, at 8:39 a.m., the BELTSS website indicated there was no current director of record listed and the last director of record had ended on November 29, 2024. On April 1, 2025, at 10:35 a.m., RD-B stated there is currently not anyone listed as the LALD director of record in the BELTSS website for this HFID and they are trying to get this updated. On April 2, 2025, at 10:30 a.m., RD-B stated she was going to check with HSE-J about the LALD director of record, they had contacted BELTSS yesterday and thought it had been approved. On April 3, 2025, at 10:40 a.m., the surveyor contacted a representative from the BELTSS website and was advised an HSE license allows a single individual professional license to be issued by the board to operate a campus of a SNF with an assisted living facility using the definition as found in 144G.08. An HSE may be shared with other communities, but a shared license for a separate campus must be applied for and issued by the BELTSS. HSE-J is the administrator of record (AOR) for a different SNF that exceeds the 60-mile radius requirement to have a shared license and so needed approval from the board. In addition, AATP-E did not have the credential to be the director of record for the assisted living	0 110		

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0 110	Continued From page 3 and has no open application for the assisted living. AATP-E can only oversee the SNF under the temporary permit. On April 3, 2025, at 10:43 a.m., the surveyor confirmed on the BELTSS website the ALFDC HFID did not have a current LALD director of record listed. On April 3, 2025, at 10:44 a.m., the surveyor confirmed on the BELTSS website HSE-J was listed as the AOR for a different SNF HFID and AATP-E was listed as the acting administrator for the attached SNF HFID. HSE-J and AATP-E were not listed as the ALFDC LALD director of record for this HFID. On April 3, 2025, at 11:25 a.m., RD-B stated she agreed no one is listed as the director of record for the ALFDC HFID and is not sure why it has not updated. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480		

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0 480	Continued From page 4 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated 03/31/2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 6 by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents) The findings include: On April 1, 2025, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director in training (LALDT)-E, director of maintenance (DM)-D, and regional director of maintenance (RDM)-F. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS: The fire-rated cross-corridor doors in Isabelle's House, adjacent to apartment 106 did not close and latch. The fire-rated door to the furnace/trash room in Vindauga View had the closer arm removed. Fire-resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with Minnesota State Fire Code.	0 775		

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0 775	Continued From page 7 EXIT DOORS AND LOCKING: The exit door from the locked memory care unit, Margaret's House, was provided with an exit sign leading to a secured patio for exiting. The gate leading to the public way (sidewalk, driveway, street) had a keyed lock installed in the exterior exit path from the patio preventing access to the public way. All marked exit doors are required to have exit paths maintained from the exit door through the exterior exit path to the public way without locks or latches that require keys, tools, or special knowledge. LALDT-E, DM-D, and RDM-F visually verified these deficient findings at the time of discovery. On April 1, 2025, DM-D stated they did not realize the doors listed above did not positively latch and would get them repaired as soon as possible. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 8 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 9 The findings include: On April 1, 2025, licensed assisted living director in training (LALDT)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire", dated August 1, 2022, and "Fire Plan", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On April 1, 2025, at 2:30 p.m., LALDT-E stated they did not have a section specific for resident actions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 10 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) 20872 for two of four employees (unlicensed personnel (ULP-H and ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety)and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's HFID was 20872. The licensee was the owner of an attached skilled nursing facility (SNF) with HFID 00065. ULP-H was hired on January 29, 2025, to provide direct cares to residents. ULP-H was scheduled to work on March 31,	01290		

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01290	Continued From page 11 2025, evening shift from 3:30 p.m., to 9:30 p.m. ULP-I was hired on February 2, 2025, to provide direct care to residents. ULP-I was scheduled to work on March 31, 2025, evening shift train at 3:00 p.m. and April 1, 2025, evening shift train from 3:30 p.m., to 9:30 p.m. On April 1, 2025, at 11:35 a.m., regional director (RD)-B confirmed that ULP-H and ULP-I had both worked at the facility. RD-B stated they must be affiliated with the attached SNF HFID but will need to confirm after checking and if they are not affiliated with this HFID it would be due to starting at the SNF or an error on their part. On April 1, 2025, at 1:28 p.m., the surveyor received an email from RD-B that contained background study clearance letters for both ULP-H and ULP-I that showed affiliation with the SNF HFID 00065. The email indicated, "Those two employees that you had inquired on regarding not being affiliated on the ALF NetStudy are affiliated with the SNF". On April 1, 2025, at 2:50 p.m., RD-B stated they were working on getting the ULP's affiliated with the correct HFID. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) last updated December 13, 2024, read, "If you have an existing background study for someone at one facility, you can affiliate the person's background study to another facility if the Sensitive Information Person (SIP) is the same." The licensee's Personnel Files/Employee Record	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	04/04/2025

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

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01290	Continued From page 12 policy dated November 2019, indicated the employee file shall contain: -verification of the DHS background study response. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for one of two	01540		

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	20872	A. BUILDING: _____ B. WING _____	04/04/2025

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01540	Continued From page 13 employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G was hired on September 10, 2024, to perform direct care services to residents. On April 1, 2025, at 10:00 a.m., the surveyor observed ULP-G administer medications to a resident of the facility. ULP-G's employee records had three (3) hours of documented initial dementia care training. ULP-G's employee record lacked documentation of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date. On April 1, 2025, at 2:50 p.m., regional director (RD)-B stated she agreed ULP-G was missing the full eight (8) hours of Dementia training withing 80 hours of working and this would be due to a switch in education systems they were using, some of the required classes were missed during assignment. On April 2, 2025, at 11:25 a.m., RD-B stated the dementia care training issue would be an issue for all newer employees because of the change in	01540		

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	20872	A. BUILDING: _____ B. WING _____	04/04/2025

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PARMLY ON THE LAKE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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01540	Continued From page 14 educations systems they used and there was an oversight on their part but they have assigned all the required classes to the employees affected to make sure all the employee have the required dementia training. The licensee's undated Training Requirement for Assisted Living with Dementia Care policy indicated direct care employees must have completed at least eight hours of initial training within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were stored in securely locked and substantially constructed compartments permitting only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01880		

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	20872	A. BUILDING: _____ B. WING _____	04/04/2025

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01880	Continued From page 15 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 1, 2025, at 9:00 a.m., the surveyor observed a medication refrigerator located in the unsecured unit employee office. The refrigerator did not have a lock mechanism and the door to the office was kept open even when unoccupied by employees. The medication refrigerator contained several boxes of unopened insulin pens and eye drops for several residents of the unit. On April 1, 2025, at 10:30 a.m., the surveyor observed a medication refrigerator located in the entry room of the secured unit. The refrigerator did not have a lock mechanism and the door that separated the entry room from the rest of the unit was unlocked even when unoccupied by employees. The medication refrigerator contained R2's eye drops. On April 1, 2025, at 12:35 p.m., the surveyor, in the presence of clinical nurse supervisor (CNS)-A, observed the contents of the unlocked refrigerator in the dementia care unit. CNS-A stated she agrees the medication refrigerator in the assisted living unit and the dementia care unit are both unsecured. The licensee's undated Storage of Medications policy indicated medications managed outside of a tenant's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	04/04/2025

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01880	Continued From page 16 personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of ten residents (R5 and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 1, 2025, at 9:00 a.m., the surveyor observed the medication cart in the unsecured unit with unlicensed personnel (ULP)-C. The	01890		

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01890	Continued From page 17 surveyor noted expired medications for R5 and R6. ULP-C confirmed expired medications with the surveyor. R5 had the following expired medication: -loperamide 2 mg (for loose stools), expired on March 18, 2025. R6 had the following expired medication: - Tylenol 325 mg (for pain), expired on March 14, 2025. On April 1, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated the expired medications found in the medication cart must have been missed by the overnight staff because they are delegated the task of checking the medication carts on their shift. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/31/25*
Time: 11:00:00
Report: 1025251074

Food and Beverage Establishment Inspection Report

Location:
Parmly On The Lake
28210 Old Towne Road
Chisago City, MN55013
Chisago County, 13

Establishment Info:
ID #: 0038378
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6512577334
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders previously issued on 12/12/22 have NOT been corrected.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Provide coolers in Izzy kitchen that meets the above standards for storing TCS foods (facility prepares foods for multi-day service). See additional comments.

Issued on: 12/12/22 *Comply By: 12/12/22*

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

Hardboiled eggs in Margaret kitchen without a date mark, mark the date of ready to eat TCS foods when opened in the facility

Comply By: 03/31/25

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Provide a means of testing the interior of the dish machines in the neighborhood kitchens

Comply By: 04/02/25

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	1

Main Kitchen
HB egg package walk in cooler 40 deg F
Discussed cooling TCS foods - reported cooled on metal pans and placed in bags for storage
Upright cooler corner TCS pkg 41 deg F
(Serving line in kitchen for SNF 155 deg F)
Dish machine 180 rinse 160 contact, rinse gauge hidden (by exhaust and wall, note that the walls and doors in dish area are not required per MN 4626, but may be as part of any SNF licensing), observed with phone camera at 15 PSI, reported units are routinely serviced by a third party, ensure rinse pressure is checked since it is in a hard to see/reach location
Chemical storage, quat ammonia replaced during inspection 300 PPM tested

Isabelle/Izzy
Provide a means of testing the interior contact temperature in the dish machine; rinse gauge not functional on unit
Personal canned items stored in refrigerator, reported that these are brought by family and consumed only by the resident and are not shared with other residents - segregate all personal food
Resident washing dishes (activity) during inspection however dishes were placed in a drying rack and attempted to be put away without running through a dishwasher. Staff instructed resident to put items in the dish machine. While it's understandable residents will participate in daily activities in the kitchen, they still must follow the same requirements of MN 4626, including sanitizing all dishware and drying hands on a paper towel, cloth towels should not be used for drying hands or items (a towel was offered to inspector to dry their hands, and while this was a polite thing to do, towels shouldn't be provided to the resident for drying if the kitchen is going to be used as part of the actual food serving facility and not just as an activity/enrichment area in such a way the requirements of MN 4626 are not followed).

Margaret
HB eggs in upright cooler without a date mark - ensure all TCS foods are date marked appropriately. As this cooler meets the requirements of MN 4626.0506, it can be used to store facility provided TCS foods.
Provide a means of testing the interior contact temperature in the dish machine

View
Ambient upright cooler 40 deg F
Dish machine not in use during inspection; test before next use by staff using the puck TMD

Type: Full
Date: *03/31/25*
Time: 11:00:00
Report: 1025251074
Parmly On The Lake

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025251074 of 03/31/25.

Certified Food Protection Manager: Erika Radman

Certification Number: FM123804 Expires: 04/18/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us