Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 10, 2025

Administrator
Parmly on the Lake LLC
28210 OLD TOWNE ROAD
CHISAGO CITY, MN 55013

RE: CCN: 245328
Cycle Start Date: June 12, 2025

Dear Administrator:

On August 5, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2025

Administrator
Parmly on the Lake LLC
28210 OLD TOWNE ROAD
CHISAGO CITY, MN 55013

Re: Reinspection Results
Event ID: EQO8-H2

Dear Administrator:

On August 5, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 1, 2025

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

RE: CCN: 245328
Cycle Start Date: June 12, 2025

Dear Administrator:

On June 12, 2025, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	**28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 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
E0000	Initial Comments On 6/9/25-6/12/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. 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.	E0000		
F0000	INITIAL COMMENTS On 6/9/25-6/12/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiencies cited: H53286468C (MN00110393) AND The following complaint was reviewed: H53284208C (MN00112603) with a deficiency cited at F600. 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. 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	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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F0000	Continued from page 1 attained.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to protect 1 of 3 resident's (R74) right to be free from mental and physical abuse by staff. Findings include: R74's admission minimum data set (MDS) dated 4/2/25, indicated moderate cognitive impairment, did not have inattention, disorganized thinking, or an altered level of consciousness. R74 had delusions and hallucinations and verbal behavior symptoms for 4 to 6 days but not daily. Further, the behavior symptoms significantly interfered with activities or social interactions and significantly disrupted care or living environment. R74 wandered 1 to 3 days and behaviors symptoms were the same compared to prior assessment. R74 did not have impairment in range of motion, (ROM) used a walker and wheelchair and required partial to moderate assist with toileting hygiene, showering and bathing, lower body dressing, required substantial assistance with transferring, and supervision with walking 50 feet. R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after	F0600	Corrected	07/17/2025

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F0600 SS = D	Continued from page 2 cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in ROM to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, cognitive communication deficit, Parkinson's disease, and long-term use of anticoagulants. R74's Clinical Resident Profile, saved 6/10/25, indicated R74 was 85 years old. R74's care plan revised on 4/9/25, indicated R74 was hard of hearing and had bilateral hearing aids. Interventions indicated to speak clearly, repeat conversation as needed, assist resident with placing, removing, and storing of hearing aid. R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care plan revised 5/2/25, indicated R74 was a vulnerable adult and was at risk for decreased cognitive and physical abilities related to dementia with moderate behavioral disturbance and R74 experienced sundowning. Further R74 expresses feeling like he is having a nightmare but is awake and has	F0600		

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F0600 SS = D	Continued from page 3 become violent and swung objects at staff and is difficult to calm down and redirect. R74's goal was to remain free from abuse and or neglect and interventions included: allow space when R74 is upset, remove other residents from the surrounding area, remove objects of potential harm from residents nearby area, allow resident to express his frustrations, validate emotions, if resident becomes a danger to himself, residents, or staff call 911 to help deescalate the resident, monitor for signs of emotional distress or mood and behavior changes, resident will become agitated when he cannot hear. Ensure resident has his hearing aides in to allow for appropriate communication, safety monitoring will be implemented as needed to ensure resident's safety, staff will follow the facility vulnerable adult and abuse reporting policy, the local ombudsman, adult protection, police, and or state financial agencies will be notified of any suspected abuse or financial exploitation as needed, utilize de-escalation techniques with the resident. R74's care plan revised on 5/2/25, indicated R74 had an alteration in mood and behavior related to insomnia, cognitive communication deficit, urinary tract infection, as evidenced by anger at having to be in the facility, history of swearing, yelling, making statements of wanting to leave, putting self on the floor intentionally. Further, most behaviors seemed related to not wanting to be a resident at the facility. Interventions indicated to monitor and document mood, approach in a calm manner and provide resident with choices as appropriate, if resident becomes anxious remove from the crowded area. R74's Nursing Home Incident Reporting (NHIR) form dated 4/25/25, indicated R74 was combative and agitated, was swinging a foot pedal and metal shovel at staff and the nurse reported staff handled the situation unprofessionally and were unable to deescalate R74. Further, registered nurse (RN)-D and nursing assistant (NA)-G were immediately suspended and removed from the facility and immediate education to staff regarding abuse prohibition was completed among other interventions such as a full body skin assessment, monitoring orders for distress, and progress note every shift, hourly safety checks, notification of family, and R74 was evaluated by emergency medical services (EMS) and transferred to the hospital. Further, the form indicated R74 had old bruising noted to his hand, but had no signs or symptoms of physical injury.	F0600		

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F0600 SS = D	Continued from page 4 R74's 5 day Investigation Report form dated 5/2/25, indicated R74 told the director of nursing (DON) he could not hear the staff because he did not have his hearing aids in and told the DON he felt like he was in a nightmare. The report indicated according to witness, NA-H, R74 was aggressive, swearing, hitting, and punching and going back and forth between units and screamed, "Get me the fuck out of this place" and would not calm down. The form indicated NA-H stated they tried to talk to R74 and get him to let go of the foot pedal but was swinging and hitting them with it and then R74 came back with a metal shovel. NA-H went back to her unit and let the nurse and the other NA handle the situation and R74 told EMS he was having a bad dream. The report further indicated licensed practical nurse (LPN)-E heard yelling and R74 was cussing at the nurse and swinging his foot pedal at staff and RN-D was trying to get the foot pedal away from R74 and was egging him on and wondering whether R74 would hit RN-D with the foot pedal. LPN-E stated RN-D swore at R74 and kept saying, "You are going to jail, you are going to jail". LPN-E stated NA-G kept trying to get R74 back to his unit and threw a blanket over R74's head and grabbed the foot pedal away and shoved R74's head away from her to grab the foot pedal. Furthermore, RN-D stated R74 was angry and upset and swinging, yelling, and verbally abusing staff and kept going back and forth between stations. RN-D tried to do a pressure point on R74's wrist to get the foot pedal away and tried to lift his fingers off. RN-D called the police and denied touching other parts of R74's body and stated that was the aide. RN-D stated she did not engage in verbal arguments or call R74 names. Further, the form indicated NA-G stated R74 was screaming, loud, and combative and was hitting staff with something and R74 took the foot pedal that was on his wheelchair and was hitting staff with it. NA-G held R74's hands down and attempted to take away the foot pedal and shovel and threw a blanket over R74's head and NA-G was frustrated with the lack of immediate action from the nurse. The form indicated an allegation of abuse was substantiated against both RN-D, and NA-G who were immediately suspended at the time of the incident and ultimately terminated. A form, RN-D's Statement dated 4/24/25 at 12:15 a.m., completed by the director of nursing (DON) and the administrator indicated RN-D's statement. The form indicated R74 got into his wheelchair and wanted to get out of the facility and took off his foot pedal and started swinging it back and forth and knicked RN-D and they got it away from him. Further, RN-D lifted R74's fingers off the footrest by trying a pressure point	F0600		

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F0600 SS = D	Continued from page 5 that wasn't very successful and called the police about 11:30 p.m. The form further indicated RN-D tried to call the on call provider but there were issues with the phones and RN-D demonstrated on the DON's hand a pressure point and showed the actions of peeling her fingers off a pen and the form indicated RN-D used significant effort to get R74's hand off. Further the form indicated RN-D denied engaging in verbal arguments, or calling R74 a fucker. A form, NA-G's Statement dated 4/25/25 at 12:40 a.m., completed by the DON and administrator indicated NA-G's statement. The form indicated NA-G stated a guy was hitting staff and NA-G held his hands down and pushed him back to his unit and then the guy was back on their unit and had a shank or sharp shovel and there was a resident in a chair and NA-G grabbed it from behind and took it from him and then he took the leg off his chair and felt like he was going to hurt someone so "through up like it over him and took the leg a chair". NA-G felt like she de-escalated the situation. Further, the form indicated NA-G got the item from behind so he couldn't hurt her and grabbed the leg of the chair. further, NA-G told the resident she may have to call the police if he didn't calm down and the resident wasn't calming down and denied calling resident a fucker, but the form indicated NA-G threw a blanket over R74's head and grabbed the foot pedal. A form, LPN-E Statement Regarding the Incident, undated, indicated LPN-E reported an incident with a resident with a foot pedal where RN-D stated, I wonder if he will hit me with it and kept getting close to the resident and trying to grab it and the resident hit RN-D. Later, LPN-E heard a crash and the resident had a shovel and was yelling saying they were abusing him. The form further indicated LPN-E kept telling them to leave the resident and call an officer, but they kept engaging the resident and would not leave him alone. Additionally, NA-G grabbed the shovel and ripped it out of the resident's hands and the resident turned around and had the foot pedal and swung it at NA-G. LPN-E stated NA-G yanked it out of the resident's hand and grabbed the resident's head and forced his head down and stated the resident's middle finger was starting to bruise and looked swollen. Further, the statement indicated the resident kept stating stop abusing me and RN-D kept egging the resident on and the RN-D was stating you're going to jail and the resident said to call them and RN-D grabbed the residents shirt and said you little fucker. Further, the form indicated LPN-E stated they were antagonizing the resident.	F0600		

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F0600 SS = D	Continued from page 6 Additionally, the form indicated LPN-E stated NA-G threw a blanket over the resident's head. LPN-E could not recall if she saw bruises on R74's hands before the incident but thought they were already there except for the one on R74's middle finger on the right hand that was purplish. A form, NA-H Statement, undated, indicated R74 was aggressive and swearing, hitting, and punching and screaming get me out of the fucking place. The form indicated R74 was swinging it and hit himself too. The form further indicated maybe it looked worse than when it really was. NA-H stated they pulled R74's hands away and did not remember if anybody shoved R74's head and took away a foot pedal and put it at the nurses station. NA-H was on north when staff got the metal shovel and saw LPN-E, RN-D, and NA-G arguing amongst themselves and LPN-E stated it was getting abusive but NA-H did not know what happened because she wasn't present. Further, the form indicated NA-H was asked whether R74 was taunted and NA-H did not know and added they might have been, but could not identify who was talking in a way that sounded like they were taunting and further the document indicated NA-H stated, "I think the other two were in heat at the moment, you know, I don't think anybody meant too many things". NA-H later in the statement indicated she thought there may have been swearing and that it was both of them. RN-D's personnel file was reviewed and indicated a letter from the facility to RN-D dated 5/9/25, indicating RN-D was suspended on 4/25/25, and the facility was not able to reach RN-D and requested RN-D contact the facility by 5/23/25, or would take the no communication as a voluntary resignation. An additional letter dated 5/19/25, indicated a discussion occurred indicating RN-D's employment was terminated due to substantiated abuse. NA-G's personnel file was reviewed and indicated a letter from the facility to NA-G dated 4/30/25, that indicated NA-G was terminated immediately due to substantiated abuse of a vulnerable adult. R74's progress notes from 3/25/25, indicated R74 yelled and swore and was easily agitated, climbed out of his chair and was transported out of the facility for suicidal ideations while throwing himself out of the wheelchair.	F0600		

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F0600 SS = D	Continued from page 7 R74's progress notes from 3/26/25, indicated R74's physician indicated R74 had behavior changes due to prednisone use and ordered to discontinue current prednisone (a steroid medication used to reduce inflammation) order. R74's progress notes from 3/27/25, indicated R74 had increased confusion and restlessness, and agitation and a one time dose of seroquel (an antipsychotic) was ordered. R74's progress notes from 4/5/25, indicated R74 yelled and screamed and pounded on the wall, punching out, resisted cares, was physically aggressive. R74's progress note dated 4/10/25, indicated a urine culture was pending. RN-D's progress note dated 4/25/25 at 12:09 a.m., indicated R74 was yelling out and wanting out and was swinging at RN-D with his fist and verbally abusive. RN-D's note indicated R74 was left in bed and then R74 got up on his own and came out to the nursing area and hallways yelling he was kept against his will and grabbed a wheelchair pedal and started swinging it. The note further indicated they took the pedal away but R74 hit a staff person's wrist. R74 was brought down to the Park area and R74 grabbed a plant that had a garden tool in it and stated, "now I am going to get you." RN-D was concerned R74 may hurt other residents and called 911 and was taken to the hospital to be evaluated. R74's progress notes following the incident on 4/25/25 at 12:09 a.m., indicated R74 was calm and had no further behaviors on 4/25/25. R74's progress notes on 4/26/25 at 1:51 a.m., indicated R74 was agitated and irritated and declined neuro and vital sign checks. R74's progress notes were reviewed following 4/26/25, to 6/10/25, and no further behaviors were documented. R74's Weekly Skin Inspection form completed by the director of nurse dated 4/25/25 at 2:21 a.m., and locked on 4/25/25 at 4:07 a.m., indicated, "Patient has	F0600		

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F0600 SS = D	Continued from page 8 redness to right side of groin with moist area, house stock powder applied. Patient has 2+ pitting edema in top of bilateral feet. Bruising to 1 x 3 & 3 x 2 to right antecubital, 3 x 2 & 2.2x 1.2 & 2.3 x 1.4 to right wrist. 1.3 x 1.1 and 1 x 0.3 on right forearm, 3.5 x 2.5 & 0.5 x 0.5 & 0.8 x 0.4 left hand." A Fairview Health note dated 4/24/25 at 3:10 p.m., indicated from 3/27/25 to 3/29/25, R74 had a couple of falls and had possible dactylitis (an inflammation of the joints causing them to swell and appear sausage shaped) of the right middle finger and prednisone was discontinued. R74's After Visit Summary form dated 4/25/25, indicated R74 was seen for agitation and a history of dementia and quetiapine (an antipsychotic) was given on 4/25/25 at 12:43 a.m., and instructions indicated to continue with normal cares. During interview on 6/9/25 at 6:32 p.m., R74 stated he made a lot of friends at the facility and stated the help was doing their duty and further stated if you were decent with them, you received much better care. R74 further stated he wasn't satisfied at first and added he was 85 years old and had freedom all those years. R74 stated early spring time he had to go to the bathroom and pressed the button to get service, but nobody came and then a lady came and asked what he wanted and R74 stated he had to go to the bathroom. R74 stated the lady wouldn't help him by herself and had to get somebody else. R74 stated he blew up at her and they were going down the hall throwing things at each other. R74 stated he ended up at the police department, but didn't get held and stated there were two staff persons and they were no longer at the facility. R74 stated they were trying to get him to shut up and further stated all he wanted to do was get some help. R74 stated that night "she" pushed too far and hit him and was throwing stuff at him and R74 stated he threw right back. R74 stated he did not know their names and stated he felt safe and since she's out of here, R74 stated he was back to living in heaven again. During observation on 6/10/25 at 12:36 p.m., R74 was with family member (FM)-A down the hallway and no behaviors were observed. During observation on 6/11/25 at 8:53 a.m., R74 was in	F0600		

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F0600 SS = D	Continued from page 9 his wheelchair in his room next to his television and did not have any behaviors. Phone calls were placed and messages left to NA-H on 6/10/25 at 3:43 p.m., 6/11/25 at 8:04 a.m., and again on 6/11/25 10:44 a.m., however was not able to interview NA-H. During interview on 6/10/25 at 3:57 p.m., LPN-E stated she was working on a different unit on 4/24/25, and stated about 10:45 p.m., the pharmacy dropped off medications and she heard yelling from Park station and was yelling at the aide stating "you guys abused me enough tonight". LPN-E stated NA-H was trying to talk to R74 and R74 was not violent. Further, NA-H asked to close the doors to keep R74 contained on their unit and R74 went through the doors about 11:00 p.m., had a foot pedal and was screaming and RN-D stated she wondered if R74 would hit her with the foot pedal and went up to R74, put her hand close to the foot pedal and R74 hit RN-D and she grabbed the foot pedal. R74 was fine with NA-H, but then 10 minutes later, LPN-E stated she heard yelling again and a loud bang and RN-D was in the hallway and LPN-E stated RN-D stated, "I don't care we can do this all night" and walked off. LPN-E stated there was a flower pot that had a gardening shovel and R74 was holding it and was backed up against the wall and looked petrified and LPN-E stated this was not R74's normal behavior and said to call an officer and RN-D walked off. R74 came to LPN-E's unit and LPN-E stated she walked with him and again told RN-D to call 911 and RN-D walked off and R74 still had the gardening shovel and they came around the north station and NA-G came out of the nurse's office. LPN-E stated to NA-G to be careful and not approach and let R74 cool off and NA-G insisted this was her unit and reached over and pulled the shovel from behind and yanked it back wards. LPN-E stated R74 got the foot pedal and started swinging it at her and NA-G backed up and threw a blanket on R74 and NA-G pushed his head down to the right. LPN-E stated NA-G was about to start fighting R74 and R74 was so worked up he was starting to hyperventilate. LPN-E stated she told R74 he was safe and R74 broke down crying and then RN-D came back and tried pushing R74 in his wheelchair and LPN-E told RN-D to call 911. LPN-E stated RN-D and NA-G kept coming back and attacking R74. LPN-E stated RN-D was trying to push R74 and LPN-E stated RN-D told R74 he was going to fucking jail and RN-D grabbed R74's shirt and LPN-D stated RN-D told R74 he was fucking going to jail and yanked R74 back in his chair and pushed him forward with his shirt and called him a "fucker". LPN-E stated	F0600		

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F0600 SS = D	Continued from page 10 R74 kept screaming they abused him and LPN-E stated R74 was abused. LPN-E stated R74 had behaviors prior, but not like this and added that R74 was so happy now. LPN-E stated the director of nursing (DON) called her that night and both the DON and the administrator came in to the facility. LPN-E stated she worked through an Agency and stated the facility conducted training for the staff and had staff sign papers and thought she had signed paperwork on the night the incident occurred. A call was placed to NA-G on 6/11/25 at 8:28 a.m., and initially the call seemed to connect but then ended. A call was placed back to NA-G on 6/11/25 at 8:30 a.m., and went to voicemail and a message was left requesting a return call, but did not receive a return call. A call was placed to RN-D on 6/11/25 at 8:36 a.m., and a message was left, but did not receive a return call. During interview on 6/11/25 at 9:43 a.m., NA-I stated signs of abuse included hitting, leaving bruises, or taking things from residents and added they do Med Trainer online and don't have a strict meeting or learning. NA-I stated she had not heard anything from R74 and stated R74 was a sweet guy and kept to himself and had behaviors when he first came and now was the best person in the building. RN-I stated the facility comes around with pieces of paper they sign and discuss and stated she hadn't signed anything the last couple of months related to abuse that she could remember and then later stated she signed something a few months prior, but could not recall what it was for. During interview on 6/11/25 at 10:02 a.m., NA-A stated R74 did not tell her he was abused and normally liked to joke around and was sweet. NA-A stated for abuse training the facility has them complete a questionnaire and answer questions and sign a paper form and if there was an incident put something in Med Trainer. NA-A stated she had to do a couple by the end of this month and thought about a month or two ago she had to sign something but could not recall what. NA-A stated R74 had behaviors in the beginning when first admitted for the first week or so and now has been a different person. During interview on 6/11/25 at 11:42 a.m., the administrator and director of nursing (DON) stated they completed immediate education and assigned online	F0600		

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F0600 SS = D	Continued from page 11 education as well including for staff who received the immediate education. The administrator stated the DON received the call and then called her and stated the staff members did not provide care and were sitting in the lobby and were pulled in for statements and RN-D, and NA-G were suspended. R74 was sent to the hospital and told EMS he had a nightmare. The DON stated R74 received seroquel (an antipsychotic) in the hospital. The administrator stated they interviewed RN-D first at 12:15 a.m., and R74 was agitated and yelling and swinging a foot pedal. The administrator stated both RN-D and NA-G admitted to not de-escalating the situation and egging R74 on. The administrator stated NA-G and RN-D both forcefully grabbed the foot rest and NA-G threw a blanket over R74's head and when NA-G said that, that was abuse to us and explained that was not ok and suspended NA-G. The administrator stated R74 did not have any injuries and the DON completed a skin check and determined R74 didn't have any injuries. The administrator stated RN-D egged R74 on and called R74 a fucker and dared him to hit her and with the egging behavior both RN-D and NA-G were walked out of the facility and they completed a full skin check on R74 and checked other residents. RN-D had not interacted with anyone else. The administrator further stated they completed immediate education and facility wide education. The facility wide education assigned contained caring for residents with dementia and elder abuse training and assigned it for the whole assisted living facility and nursing home. The first training was person centered care for persons with dementia and the second education was identifying and reporting elder abuse. The administrator stated they did not have video monitoring and another resident was watching television and went into their room and did not witness anything. During interview on 6/11/25 at 1:39 p.m., the administrator stated she brought in a list of employees and the course name that indicated completed, however there was no date of completion on the form of the list of employees who received training. The administrator stated everyone was trained and they completed verbal education and assigned training to all staff. The administrator stated she would provide the education staff completed along with the dates education was completed. During interview on 6/11/25 at 2:50 p.m., the administrator stated they had a new system through Med Trainer and had used Google Sheets and they ran the reports and identified a handful of staff that needed	F0600		

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F0600 SS = D	Continued from page 12 to complete their education and would be calling all those staff members today to educate them and further stated they would not be using Med Trainer and would go back to Google Sheets. The administrator stated they needed to call and get ahold of NA-J and a few other people for education. During interview on 6/11/25 at 3:30 p.m., the administrator provided a form, that indicated at the top, "Course due Employee full name, Course Name, Assignment date, Assignment Status, Completion Date, and Google Sheets Education and Education. The administrator stated the employees in red were new hires and hadn't worked yet but all the staff on the top of the form with a 6/11/25, date had been educated today on Elder Abuse. The form indicated there were 11 employees who were assigned the course, "Identifying and Reporting Elder Abuse" on 4/25/25, and had a pending assignment status and were educated on 6/11/25. The form indicated NA-J had not yet received education among other staff. Later, the administrator provided an updated form that indicated 42 employees including seasonal and on-call employees were provided education on 6/11/25. During interview on 6/11/25 at 4:13 p.m., RN-A stated she heard R74 had talked about being abused through hearsay and added R74 states he feels safe and was sweet and gave bear hugs. RN-A stated R74 was never combative with her. During interview on 6/12/25 at 2:02 p.m., the administrator stated she expected staff who were assigned education to complete the education or do an alternative education like reviewing the policy and completing a verbal education and further stated they completed immediate education and contacted staff 6/11/25, and completed a verbal education. The regional director of operations (RDO)-G stated unfortunately they used a new system and would be going back to the old way. A policy, Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members, or legal guardians, friends or other individuals, or self-abuse. Further, abuse is the willful infliction of	F0600		

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F0600 SS = D	Continued from page 13 injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish and includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Further, under a heading, "Investigation/Protection" indicated corrective action based on the investigation will be completed such as change of procedure, training, discipline or discharge of staff.	F0600		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure ace wraps were applied for 1 of 1 resident, (R24) reviewed for edema, failed to ensure bruises were assessed and monitored for 2 of 2 residents (R74, R9). Additionally, the facility failed to ensure non-pressure wounds had timely assessments and documentation and provider treatment orders were followed for 1 of 1 resident (R192) who had venous wounds. Furthermore, the facility failed to ensure a referral appointment to a specialty provider was obtained for 1 of 2 residents (R78) reviewed for urinary catheters. Findings include: R24	F0684	F684 – Quality of Care Immediate Corrective Action: Immediate corrective action for R24 was to clarify order for ace wraps to include supplemental documentation to indicate if edema is present and if ace wraps were applied. Immediate corrective action for R74 and R9 included assessment and monitoring orders for bruises. Immediate corrective action for R192 included assessment of wound, treatment per order, and documentation. Immediate corrective action for R78 was to schedule urology appointment. Corrective action as it applies to others: Re-education will be provided to clinical leaders regarding need to assess and document non-pressure wounds and Injury of Unknown Origin weekly. Re-education to licensed nurses and TMAs regarding Medication and Treatment Orders policy. Re-education will be provided to HUCs regarding the importance of follow-up appointments/referrals. Facility wide audit of weekly skin checks and followed up with any identified discrepancies. The Medication and Treatment Orders Policy and the Skin Assessment and Wound Management Policy were reviewed and remain current. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be	07/17/2025

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F0684 SS = E	Continued from page 14 R24's state optional assessment (OSA) dated 5/26/25, indicated intact cognition, did not reject care, required limited assistance with bed mobility, transfers, and toilet use. R24's quarterly Minimum Data Set (MDS) dated 5/26/25, indicated R24 required partial to moderate assistance with lower body dressing and putting on or taking off footwear, did not have physical, verbal, or other behaviors, and did not reject care. Further, R24 did not have disorganized thinking, an altered level of consciousness or inattention. R24's Medical Diagnosis form indicated the following diagnoses: acute on chronic combined systolic and diastolic congestive heart failure (a condition affecting the heart's ability to pump blood), muscle weakness, adjustment disorder with mixed anxiety and depressed mood, alcoholic cirrhosis of the liver with ascites (fluid build up in the space between the lining of the abdomen and abdominal organs), fluid overload, and generalized edema (an accumulation of fluid in the interstitial spaces throughout the body leading to swelling). R24's physician's orders indicated the following order: • 7/19/24, monitor, document, and report to physician as needed any signs or symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. • 4/24/25, torsemide (a diuretic) oral tablet give 40 milligrams (mg) by mouth two times a day related to cirrhosis of the liver. •	F0684	Continued from page 14 completed on five residents for Weekly Skin Checks to ensure completion to ensure completion weekly x4 and then monthly for x2. Audits will be completed on five residents for Skin and Wound Forms weekly x4 and then monthly for x2. Audits will be completed on five residents to ensure treatments are completed per provider order weekly x4 and then monthly for x2. Audits will be completed on five residents for appointment scheduling weekly x4 and then monthly for x2. Discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	

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F0684 SS = E	Continued from page 15 4/24/25, spironolactone oral tablet give 150 mg by mouth one time a day for diastolic heart failure related to generalized edema. • 5/3/25, "Complete daily edema checks to BLE. [bilateral lower extremities] apply ACE wraps PRN [as needed] if patient requests or edema is noted every day shift for". R24's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated the following order dated 5/3/25, "complete daily edema checks to BLE. Apply ACE wraps PRN If patient requests or edema is noted. every day shift for". The MAR/TAR had a check box indicating the treatment was administered every day from 6/1/25, to 6/11/25. R24's care plan dated 9/24/24, indicated R24 had congestive heart failure and interventions included to monitor, document, and report to the physician as needed any signs or symptoms of congestive heart failure including dependent edema of the legs and feet. R24's care plan dated 2/17/25, indicated R24 had an alteration in skin integrity due to localized edema, lymphedema to BLE's, ascites to abdomen and an intervention revised on 7/31/24 indicated R24 had Velcro wraps to BLE's managed by the therapy department however R24's mobility care plan indicated the Velcro wraps were resolved on 1/6/25. R24's nursing progress notes dated 6/6/25 at 5:57 a.m., indicated R24 had edema in the right lower extremity. R24's nursing progress notes dated 6/7/25 at 3:46 p.m., indicated R24 had edema present to the right lower extremity. R24's nursing progress notes with MAR were reviewed 6/6/25 to 6/12/25, and lacked information R24 refused ACE wraps. R24's Daily Skilled Note form dated 6/11/25 at 11:16	F0684		

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F0684 SS = E	Continued from page 16 a.m., in progress indicated R24 had edema to the right lower extremity. The form contained five check boxed options for cardiovascular interventions that included: elevated affected extremity, compression stockings applied as ordered, encouraged resident to change position slowly, administered cardiovascular medications as ordered, and physician notified of cardiac complications. Documentation on the form indicated R24's extremity was elevated and was encouraged to change positions slowly. The note further indicated R24's edema was improved. During interview and observation on 6/9/25 at 7:12 p.m., R24 had edema to lower extremities and R24 stated he had all his toes amputated on the left foot. R24 had gripper socks on, and his legs were dependent. R24 stated he could get his legs wrapped but stated the nurses never have any time. R24's MAR and TAR indicated his treatment order for monitoring for edema and applying ACE wraps as patient requests or if edema is noted was documented as administered. During interview and observation on 6/11/25 at 2:32 p.m., R24 stated he wanted his legs wrapped but did not get legs wrapped and stated he mentioned he wanted his legs wrapped to the nurse, but the nurse didn't wrap his legs. Reviewed the MAR/TAR that indicated monitoring for edema and applying ACE wraps as patient requests or if edema is noted was documented as administered. R24 stated he was supposed to take diuretics but then has to urinate. R24 had edema to mid-calf region of legs and wanted his legs wrapped to keep the swelling down. During interview on 6/11/25 between 2:54 p.m., and 3:00 p.m., registered nurse (RN)-A stated staff knew what cares a resident required thru the care plan and staff documented in a progress note or a note from the MAR and TAR if a resident refused. RN-A stated R24 was alert and a reliable historian who required assistance with dressing. RN-A stated R24 had not had edema and had not seen edema around R24's legs. RN-A further stated when a treatment was completed, it was documented in the TAR. At 3:00 p.m., RN-A viewed R24's legs and stated they looked swollen and verified R24 did not have ACE wraps on. RN-A viewed R24's order and stated the order should have been two orders, to check for edema and apply ACE wraps if resident requested or if edema was noted and stated it needed clarification and she could edit that.	F0684		

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(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
F0684 SS = E	Continued from page 17 During interview on 6/12/25 at 1:10 p.m., nurse care coordinator licensed practical nurse (LPN)-A stated she expected staff apply ACE wraps if there was an order and a resident requested them. LPN-A stated if an order was scheduled and a resident refused, the refusal should be documented and stated R24 did not like to take his full diuretic because he didn't want to void and had significant abdominal edema in the past. LPN-A further stated R24 was alert and oriented and lets staff know what he wants. LPN-A stated it had been a few days since she saw R24's legs. LPN-A verified R24's MAR/TAR had a check mark under R24's order to check for edema and apply ACE wraps if resident requested or if edema was noted and verified R24's skin form dated 6/11/25, indicated R24 had edema and stated they needed to clarify the order and would make sure it was clearer and planned to follow up with nurses to follow the order. R74 R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in range of motion to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. Additionally, R74 took an anticoagulant (blood thinner), and did not use a bed rail. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, and long term use of anticoagulants. R74's care plan dated 4/1/25, indicated R74 had a self care deficit related to confusion, urinary tract infection, catheter use, and required assist of one	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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F0684 SS = E	Continued from page 18 with bathing, dressing, and personal hygiene. R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care sheet dated 6/6/25, indicated R74 was on anticoagulants, but lacked information R74 had a bruise. R74's Physician Orders form indicated the following orders: • 3/28/25, weekly skin inspection by licensed nurse every Friday evening shift. Complete the weekly skin inspection in PCC. • 6/3/25, Warfarin (a blood thinner) 1.5 milligram (MG) by mouth every Monday, Tuesday, Wednesday, and Friday at HS (hour of sleep) until 6/16/25. • 6/5/25, Warfarin 1 mg by mouth every Thursday, Saturday, and Sunday at HS until 6/16/25. • 6/8/25, make a progress note post fall for 72 hours. Make sure to include any signs or symptoms of injury and effectiveness of new fall interventions. • 6/8/25, monitor for signs and symptoms of injury post	F0684		

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F0684 SS = E	Continued from page 19 fall for 72 hours every shift for three days. • R74's orders lacked direction for monitoring or assessing the bruise to R74's inner side of right arm identified in the nursing progress notes on 5/28/25. R74's medication administration record (MAR) and treatment administration record (TAR) for May 2025, indicated R74 had a weekly skin inspection on 5/2/25, 5/9/25, 5/16/25, 5/23/25, and 5/30/25. Further, the MAR/TAR lacked direction to monitor or assess R74's bruise to the inner side of the right arm identified on 5/28/25. R74's MAR/TAR for June 2025, indicated R74 had a weekly skin inspection on 6/6/25. Additionally, the MAR/TAR indicated staff documented 6/8/25, and 6/9/25, they monitored for signs and symptoms of injury post fall. The MAR/TAR lacked documentation R74's bruise to the inner side of the right arm identified on 5/28/25, was monitored or assessed. R74's nursing progress notes were reviewed and indicated on 5/28/25 at 5:50 p.m., a nursing assistant reported a bruise on R74's inner side of right arm and the nurse asked about the cause. The progress note indicated R74 responded, "Don't ask me, I don't know when and how it happened." Further, the bruise measured approximately 4.5 inches long by 3.5 inches wide and R74 denied pain and further, staff would continue to monitor. R74's nursing progress notes dated 6/7/25, indicated R74 was observed falling and hitting his head on the wall. R74 reported his right knee went out and got caught when turning. Under a heading, "Nursing assessment for s/s [signs and symptoms] or pain and/or injury:" indicated R74 had redness to his posterior scalp, and reported right knee discomfort. The note lacked information regarding R74's bruise to his right inner arm. R74's nursing progress notes dated 6/9/25, indicated R74 had a small abrasion to the right knee. The progress notes lacked information regarding R74's bruise to his right inner arm.	F0684		

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F0684 SS = E	Continued from page 20 R74's nursing progress note dated 6/10/25 at 4:25 a.m., indicated R74 had no new injuries related to a recent fall. R74's Weekly Skin Inspection form dated and locked on 5/2/25, indicated R74 had no new skin issues noted. R74's Weekly Skin Inspection form dated 5/12/25, and locked on 5/14/25, indicated R74's skin was clean, dry, and intact. R74's Weekly Skin Inspection form dated and locked on 5/16/25, indicated R74's skin was clean, dry, and intact. R74's Weekly Skin Inspection form dated on 5/25/25, and locked on 5/26/25, documented by registered nurse (RN)-A indicated R74 had redness to the groin area, additionally, R74 had purple discoloration to the right upper arm and had no complaints of pain. The note lacked documentation of the size of the discoloration, where on the upper arm the discoloration was, or how R74 obtained the purple discoloration. R74's Weekly Skin Inspection form dated and locked on 5/30/25, indicated R74's skin was clean, dry, and intact and had a pink area to the groin and powder was applied. R74's Weekly Skin Inspection form dated and locked on 6/9/25, indicated R74's groin was slightly pink with no open areas and treatment was in place. Further, the note indicated R74 had a pink area to the top of his head from a fall and was not open. During interview and observation on 6/9/25 at 6:45 p.m., R74 had a very large bruise on his right upper inner arm. The bruise was dark purple and was located on the inner side of his arm from his shoulder and extended down to just above R74's elbow. The bruise was approximately 4 inches wide. R74 stated he didn't know what he did to sustain the bruise and stated he had an inkling of what could have happened. R74 stated the hospital beds have those things, R74 pointed to the hand rails on the bed and stated he had a feeling he	F0684		

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F0684 SS = E	Continued from page 21 got his arm caught in the rail and it finally came out. R74 stated he never woke up and didn't know for sure and added, what else could happen when you are laying in bed. During observation on 6/11/25 at 8:53 a.m., R74 was in his wheelchair and his arms were on the inside of the wheelchair resting in his lap. At 8:57 a.m., R74 propelled himself out of his room and his right and left arms were on the arm rests of the wheelchair from wrist to elbow. Did not observe R74 bumping into anything. During interview on 6/11/25 at 10:02 a.m., nursing assistant (NA)-A stated she cared for R74 today and provided R74 a wash cloth and further stated she assists R74 with dressing adding, she got R74's clothes out of the closet and helped donn R74's shirt and stated R74 could put his arms thru the sleeves. NA-A stated R74 did not refuse cares. NA-A stated she would have to report findings of bruises, scratches, and reddened areas. During interview and observation on 6/11/25 at 4:13 p.m., RN-A stated staff used care plans to know what cares a resident required and nurses communicate changes. RN-A further stated refusals were documented in a progress note and in the MAR/TAR if the refusal was a treatment or medication and nursing assistants update the nurses. RN-A stated when a resident falls, they check the resident for injuries and complete skin assessments the next few days and monitor a resident for 72 hours after a fall. RN-A stated she thought R74 fell on his right side. RN-A stated if a resident did not know how a bruise occurred, would pass the information on to a supervisor to conduct an investigation. RN-A stated bruises that were light green or yellow were older, and bruises that were red or purple were newer and further stated bruises were monitored weekly on a skin assessment and were added as a treatment in order to monitor them. RN-A viewed R74's record and verified R74's Weekly Skin Inspection form dated 6/9/25, did not mention R74's bruise to the arm. RN-A viewed the skin assessment form dated 5/25/25, that indicated R74 had a purple discoloration to his right upper arm. RN-A further viewed R74's progress note dated 5/28/25, that indicated R74 had a bruise to the inner side of the right arm that measured 4.5 inches long by 3.5 inches wide and further R74 did not know what happened. RN-A stated she documented R74 had purple discoloration but did not measure the	F0684		

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F0684 SS = E	Continued from page 22 discoloration and did not report it to another person. RN-A stated R74 told her the other night he may have reached between his rail. RN-A viewed R74's arm and stated the bruise was fading and was a purple blue in color to the inside of R74's arm. During interview on 6/11/25 at 4:59 p.m., LPN-A stated she expected staff document the bruise. LPN-A goes over progress notes in the a.m., and if she finds a progress note of the skin they try to figure out where it came from. LPN-A further stated if staff find a bruise and it is not documented on admit and staff do not know, it needs to be documented or they need to tell someone. LPN-A further stated she or others will complete an investigation and findings should be in a progress note and further stated monitoring should be on the TAR. LPN-A stated she was not aware R74 had a bruise and asked where the bruise was located and stated she would have to check. LPN-A verified R74 had a progress note dated 5/28/25, that indicated R74 had a bruise and resident did not know what happened. LPN-A viewed R74's orders and verified there were no orders for monitoring R74's bruise. LPN-A viewed R74's incidents and verified there was no investigation conducted. LPN-A stated she did not know how she missed that one. LPN-A stated R74 could remember some things and was better when his wife was at the facility. LPN-A verified R74 had a bruise on his right inner arm and R74 stated the only thing he could figure out was that his arm was in one of those brackets and pointed to the bed rail and LPN-A asked R74 if she could measure the bruise. During interview on 6/11/25 at 5:25 p.m., LPN-A later stated she went back through the morning stand up meeting note on 5/28/25, and stated the investigation was completed and R74's bruise was likely due to hitting his arm on on the wheelchair and R74 repositioned self a lot with his arms and stated R74 should have had monitoring in place. A copy of the interdisciplinary team (IDT) note was requested. A progress note was later added by LPN-A on 6/11/25 at 6:01 p.m., that indicated R74's bruising was reviewed in IDT on 5/28 and was determined through investigation and observation R47 was leaning over to get something off the floor and bruising was from the wheelchair arm. Further the bruising was purple, diffused with faded edges and measured 24 by 7 and monitoring orders were placed. The note further indicated R74 felt safe and no one harmed him. Additionally, the note indicated the provider was updated on the increased size of the	F0684		

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F0684 SS = E	Continued from page 23 bruise who provided a telephone order for daily measurements, ultrasound, and a new INR (International Normalized Ratio, a lab that measures how long it takes for blood to clot). During interview on 6/12/25 at 8:49 a.m., with the administrator and LPN-A, LPN-A stated R74's bruise measured 24 centimeters (CM) by 7 cm (approximately 9.4 inches by 2.7 inches) and further stated they updated the physician the bruise increased in size and an INR and ultrasound was ordered. The IDT report was again requested and the administrator stated she would pull that information. The administrator stated if an injury was identified, the director of nursing and administrator are notified at standup or if out side that period are notified of a bruise by the nurse or nurse manager and investigate by asking the resident if they know if anyone hurt them, whether they feel safe, observe transfers, mobility and if bumping into edges and stated R74 leans over and grabs things. Once a bruise is identified the family, provider, are notified and monitoring orders are placed and the provider may provide additional orders and would have expected the bruise to be monitored in the medical record. An email sent by the administrator on 6/12/25 at 9:23 a.m., contained a PDF document titled, "5.28 stand up skin". The form indicated, "Wound-Skin Concerns" at the top and was highlighted in yellow. The form contained a section for names, skin concerns, and progress. R74's skin concern indicated R74 had a bruise to the right upper extremity that was new from hitting the wheelchair. An additional PDF document titled, "5.28 24-hour" was also provided that indicated R74 had a bruise on the inner side of the right arm that included measurements 4.5 by 2.5 from hitting on wheelchair per investigation and observation. During interview on 6/12/25 at 9:26 a.m., family member (FM)-A stated she wasn't sure how R74 got the bruise and wondered if R74 got stuck on the thing inside of the bed or if R74 leaned over the side of the wheelchair and thought it was either due to the side rail of the bed or leaning over. FM-A stated she had received more than a call on the bruise and stated the facility tried to figure out how it happened, but didn't think it was on 6/11/25. R192	F0684		

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F0684 SS = E	Continued from page 24 R192's admission Minimum Data Set (MDS) dated 6/2/25, indicated R192 was cognitively impaired and had diagnoses of peripheral vascular disease (PVD) and non-pressure chronic ulcers of the feet. R192 had 5 venous ulcers that required dressing changes. R192's provider order dated 6/6/25, indicated R192 required wound care to bilateral lower extremities that included cleanse wounds, pat dry, apply Aquacel AG or calcium alginate AG, gauze, kerlix and ACE wrap every other day and as needed. R192's skin Care Area Assessment (CAA) dated 6/2/25, indicated R192 had PVD and multiple lower extremity wounds with infection. Wound nurse to follow in-house. R192's skin and wound evaluations dated 5/30/25, were started however were still in progress, however all wound assessments had not been completed with description of the wound bed, exudate, pain, infection, and treatment. R192's skin and wound evaluations dated 6/6/25, were started however were still in progress. The assessment had not been completed with completed with description of the wound bed, exudate, pain, infection, and treatment. R192's weekly skin assessment dated 6/6/25, indicated R192 had wounds, but lacked assessments of the wounds. R192's care plan dated 6/2/25, indicated R192 had chronic wounds and wound infection to bilateral lower extremities. Interventions included treatment to open areas per order and weekly measurements and assessments. An observation on 6/10/25 at 1:37 p.m., licensed practical nurse (LPN)-F brought R192 into their room to perform dressing changes. R192's socks were removed and both feet had kerlix wrapped on them, however they did not have ace wrap as ordered. LPN-F completed the dressing change per order with the exception of wrapping R192's feet with ace wrap.	F0684		

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F0684 SS = E	Continued from page 25 When interviewed on 6/10/25 at 2:20 p.m., LPN-F stated this was the first time working with R192. LPN-F stated wounds were assessed and measured at least weekly maybe at every dressing change. LPN-F wasn't sure what the process was at this facility as they were an outside agency nurse. LPN-F further stated if something looked off could measure them at any time as well. LPN-F stated there was a lot of drainage but was not sure if that was normal for the wounds or not. LPN-F verified R192's wounds did not have an ace wrap as ordered and they had not placed one as she did what was done previously. When interviewed on 6/10/25 at 3:39 p.m., registered nurse (RN)-C stated all residents who have wounds were followed by the wound nurse and rounds occurred on Friday. This was when the wound had picture measurements taken and a complete assessment of the wound was completed. The managers rounded with the wound nurse and then go back and document the assessments. RN-C verified R192's wound assessments were not complete for 5/30/25 and 6/6/25. RN-C stated the note from 5/30/25 should have been completed within a day or 2 after the assessment was done. However, R192 had missed wound rounds on 6/6/25 as they were at a podiatry appointment. RN-C stated if wound rounds were missed, the assessment and measurements could be completed during the weekly skin check or during a dressing change. RN-C verified R192's wounds were not assessed by the facility for that week, but would have been assessed at their podiatry clinic. RN-C further expected staff to follow the wound care orders and if an ace wrap was ordered, it should be placed. When interviewed on 6/12/25 at 1:24 p.m., the Director of Nursing (DON) expected staff to fully document wound assessments upon weekly skin checks and during wound rounds. If the resident was unavailable, the nurse manager would follow up on the next business day to complete the measurements and assessment. R78 R78's admission Minimum Data Set (MDS) dated 5/15/25, indicated R78 had severely impaired cognition and diagnoses of stroke with right sided paralysis. R78's hospital discharge summary dated 6/3/25, indicated R78 had urinary retention with incomplete	F0684		

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F0684 SS = E	Continued from page 26 bladder emptying while in the hospital. R78 was discharged with orders for a foley catheter and a referral to see a urologist to follow up with the urine retention. Next to this order was a staff initial. At the top of the discharge orders was a nursing staff signature. R78's care plan dated 5/14/25, indicated R78 was at risk for an alteration in elimination related to stroke, and urine retention. Interventions lacked indication R78 had a foley catheter. R78's electronic medical record (EMR) lacked indication R78 had a follow up appointment with urology. An observation on 6/9/25 at 5:49 p.m., R78 was lying in bed. R78's catheter bag was hanging on the side of the bed. Family member (FM)-B was visiting R78 and stated they were not sure why the catheter was in place. FM-B further stated R78 was supposed to have a urology appointment but was not sure if anything ever got set up. When interviewed on 6/11/25 at 10:04 a.m., licensed practical nurse (LPN)-F verified R78 had come back from a hospitalization with a referral to see a urologist. LPN-F further stated when the health information coordinator (HIC)-F made resident appointments. When an appointment was made, an order went in communicating the date and time of the appointment. When interviewed on 6/11/25 at 1:16 p.m., HUC-A and trained medication assistant (TMA)-A stated when a resident was admitted, the orders were reviewed and entered into the EMR and this included specialty referrals. HIC-F stated when the orders were placed was when the process for making appointments was completed. After the appointment was made, the information was entered into an order for nurses to see. TMA-A had been helping with orders and appointments for a few weeks and had placed R78's hospital discharge orders into the EMR. TMA-A reviewed R78's discharged orders and stated she had not initialed the urology referral and had missed that order. TMA-A stated her initials were on all the other orders and that was how she tracked what was entered. TMA-A stated the urology was also missed during the second check by the nurse as the orders had been signed off by registered nurse (RN)-C. TMA-A stated they would work on this appointment right away.	F0684		

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F0684 SS = E	Continued from page 27 When interviewed on 6/12/25 at 9:05 a.m., registered nurse (RN)-C stated when residents were admitted or re-admitted with a catheter, their orders would either indicate when a trial void was needed or if a follow up with urology was needed. Any referrals that were ordered were part of the admission orders and would first be placed by the HUC and then double checked by the nursing staff. The appointments would be made within the first few days of admission and an order placed in the resident chart. RN-C verified R78's referral order had not been worked on right away and further stated she was in contact with urology this morning to clarify orders since the appointment made yesterday was so far out. When interviewed on 6/12/25 at 1:24 p.m., the Director of Nursing (DON) stated any referral appointments would call the facility to schedule the appointment. DON expected staff to follow up with them if it had been a week since the referral was ordered and the clinic had not called. A policy, Skin Assessment and Wound Management, dated 2/2025, indicated staff performed routine skin inspections with daily care, and nurses were to be notified if skin changes were identified, and weekly skin inspections were completed by licensed staff. When a significant alteration in skin integrity is noted such as large or multiple bruising, large skin tears, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers, the following actions will be taken: notify the provider, treatment ordered, notify the resident representative, initiated skin and wound evaluation, notify the nurse manager and wound nurse, review and update the care plan including interventions. Follow ongoing treatments per provider order, update the provider and resident representative as needed and update the care plan as needed. A facility policy for follow up appointments/referrals was requested however was not received. R9 R9's admission Minimum Data Set (MDS) dated 3/14/25, indicated intact cognition and diagnoses of heart failure, spinal stenosis, chronic pain, and long-term	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 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
F0684 SS = E	Continued from page 28 use of anticoagulants. If further indicated R9 required staff assistance with most activities of daily living (ADL) and mobility, and received an anticoagulant on a routine basis. R9's physician's orders dated 3/8/25, indicated bilateral tubigrip to both arms (from wrist to elbow areas), on in morning (a.m.) and off at hour of sleep (HS), two times a day. R9's physician's orders further indicated to monitor bruising until resolved, once resolved discontinue order and write a progress note, every shift. R9's order to monitor for bruising lacked a location or description of the bruising. R9's care plan dated 3/14/25, indicated potential for alteration in blood formation and coagulation, related to the use of anticoagulant medication. It further indicated the following interventions: -anticoagulant Medication as ordered by the medical doctor (MD) or physician's assistant (PA) -monitor labs (ie. Protime) as ordered. -monitor and notify MD of signs and symptoms of bleeding. -encourage resident to avoid bumping self. Use soft toothbrush. -monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, bruising, lethargy, sudden changes in mental status and/or vital signs, shortenss of breath (SOB), and nose bleeds. During observation on 6/10/25 at 9:33 a.m., R9 was not wearing her bilateral Tubi-grips and had a large heart shaped bruise on her left wrist/forearm. During observation on 6/11/25 at 9:38 a.m., R9 was laying in bed, was not wearing her bilateral Tubi grips, and had a large heart shaped bruise on her left wrist.	F0684		

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F0684 SS = E	Continued from page 29 During observation on 6/11/25 at 1:30 p.m., R9 was laying in bed, wasn't wearing her bilateral Tubi-grips, and had a large heart shaped bruise on her left wrist. During interview on 6/11/25 9:54 a.m. licensed practical nurse (LPN)-B stated when a resident had a bruise, it should be documented in the progress notes and put in the orders to monitor it until it was resolved. The orders to monitor should be specific to the bruise and provide a location and description. LPN-B further stated the bruise may also be documented on the skin assessment. During interview on 6/11/25 at 1:38 p.m., NA-A stated NA's were responsible for applying the residents Tubi-grips and verified R9 wasn't wearing hers and should have been. NA-A further stated R9 sometimes refused to put them on but she had not offered/attempted to put them on her today. If R9 refused the Tubi-grips (or other cares) it should be documented. During interview on 6/11/25 at 1:55 p.m. licensed practical nurse (LPN)-C stated when a resident was noted to have a bruise, it should be measured and investigated (to determine the cause), and orders should be put in for monitoring. LPN-C further stated the orders should be specific to the location of the bruise and include a description of it. The bruise should be monitored until it was resolved. LPN-C also stated NA's and nurses were responsible for applying resident Tubi-grips and if the NA applies them, the nurse was responsible for ensuring they were on and then documenting it. Refusals should also be documented. During observation on 6/12/25 at 12:10 p.m., NA-B verified R9 had a large heart shaped bruise on her left wrist. NA-B stated NA's were responsible for reporting bruises to the nurse. R9's Weekly Skin Inspections for the month's of May and June of 2025 lacked documentation of a large heart shaped bruise on R9's left wrist/forearm. R9's Skin and Wound Evaluations for the months of May and June 2025 lacked documentation of a large heart	F0684		

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F0684 SS = E	Continued from page 30 shaped bruise on R9's left wrist/forearm. R9's progress notes for 6/1/25-6/12/25 lacked documentation of R9 having a large heart shaped bruise on her left wrist/forearm.	F0684		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure range of motion (ROM) exercises were completed for 1 of 2 residents (R12) reviewed for ROM. Findings include: R12's annual Minimum Data Set (MDS) dated 3/10/25, indicated R12 was cognitively intact and had diagnoses of quadriplegia (paralysis that impacts all 4 extremities) R12 required substantial to complete assistance with mobility. R12's physical therapy nursing communication form dated 6/26/24, directed staff to complete ROM exercises and stretching exercises daily. The program was posted in R12's room.	F0688	F688 – Range of Motion Immediate Corrective Action: R12 has expired. Corrective action as it applies to others: Re-education provided to clinical leaders on correct order entry for Range of Motion programs. Audit like-residents ROM documentation. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be completed on three residents to ensure their ROM programs are being completed and documented on weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	07/17/2025

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F0688 SS = D	Continued from page 31 R12's interdisciplinary department team (IDT) care conference form dated 3/10/25, indicated R12 wanted staff to complete ROM exercises. R12's care plan revised 4/2/25, indicated R12 had an alteration in mobility related to weakness, quadriplegia and right foot drop. Interventions lacked a ROM exercise program. During an observation and interview on 6/9/25 at 1:09 p.m., R12 was in their room in bed. R12 stated staff were supposed to be helping with exercises twice a day. R12 stated there used to be a sign on the wall to show staff what exercises were needed and R12 gestured around the room and stated "it's gone". The exercises were started after therapy ended and just wasn't happening anymore. When interviewed on 6/12/25 at 6:59 a.m., nursing assistant (NA)- A stated if a resident required ROM exercises, it would be on the NA care sheet. When the exercises were completed, they would be documented in the computer. NA-A stated residents can refuse and that would be documented too. NA-A verified R12 required ROM exercises and it was listed on the task sheet. NA-A wasn't sure what exercises were needed, and thought it was for his legs and the sign in R12's room would tell staff what was needed. NA-A verified the ROM sign was no longer in R12's room and was not sure what happened to it and stated R12 would ask if he wanted it and would let staff know what to do. When interviewed on 6/12/25 at 2:49 p.m., licensed practical nurse (LPN)-A stated residents who had ROM exercises would have that noted on the NA care sheet as well as a sign in their room. The sign would show staff what kind of exercises were recommended and how many should be done. LPN-A stated R12 was particular and wants to move more and then refuses to do so. LPN-A stated there should be a sign in R12's room and NA staff should be documenting when it was completed or refused. LPN-A reviewed the point of care documentation and stated there was not an option for documentation. LPN-A stated they could not verify if R12 had been recently receiving ROM exercises. A facility policy for ROM was requested however was not	F0688		

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F0688 SS = D	Continued from page 32 received.	F0688		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure cares were provided to minimize risk of aspiration (inhalation of saliva or stomach contents) for 1 of 1 residents (R78) reviewed who required continuous tube feeding. Findings include: R78's admission Minimum Data Set (MDS) dated 5/13/25, indicated R78 had severely impaired cognition and diagnoses of stroke with right sided paralysis and dysphagia (inability to effectively swallow). R78 was dependent on staff for toileting cares and required assistance of one for bed repositioning. R78 received nothing by mouth for nutrition and required continuous tube feeding via a gastrostomy (G-tube, tube in the stomach to provide tube feed nutrition). R78's provider order dated 5/9/25, indicated R78	F0693	F694 – Tube Feeding Management/Restore Eating Skills Immediate Corrective Action: Immediate corrective action for R78 clarify order for appropriate tube feeding procedure with cares. Corrective action as it applies to others: Reviewed and revised Enteral Feeding/Safety Precautions policy and revised batch order set for tube feeding. Education to licensed nurses, TMA's, and NAR's regarding updates to policy and batch orders. Audit like-residents and corrected discrepancies. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits of enteral feeding orders for all residents on tube feeding will be completed weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	07/17/2025

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F0693 SS = D	Continued from page 33 required the head of bed (HOB) elevated at least 30 degrees during feeding and to pause feeding for 30-60 minutes prior to initiating personal cares where the resident will be lying flat. R78's provider order dated 6/8/25, indicated R78 required Vivonex oral liquid nutritional supplement at 70 milliliters per hour every hour via G- tube for continuous feeding. R78's provider note dated 6/5/25, indicated R78 was hospitalized for aspiration pneumonia from 5/30/25-6/2/25. R78's care plan dated 5/14/25, indicated R78 was at risk for aspiration related to the presence of tube feeding. Interventions included to administer tube feeing as ordered, keep HOB elevated at least 45 degrees during and after feeding, and monitor for signs/symptoms of aspiration. An observation on 6/11/25 at 7:58 a.m., nursing assistant (NA)-F entered R78's room to offer repositioning and incontinent cares. R78 was lying in bed with the HOB at approximately 35 degrees and had his tube feeding running. R78 was agreeable to cares and at 8:00 a.m., NA-F lowered R78's HOB flat and assisted R78 to roll to the right side. NA-F determined R78 had a soiled brief and proceeded to provide incontinent and catheter cares. R78 was rolled back and forth mainly on to their right side. R78 coughed a few times when on his right side. The cough sounded wet. NA-F completed the cares and at 8:20 a.m., and then raised R78's HOB back to approximately 35 degrees before leaving R78's room. When interviewed on 6/11/25 at 8:23 a.m., NA-F stated any specific cares needed for residents were found on the care sheets. NA-F stated two staff were needed to boost the resident, however, R78 could roll to the right side well so cares could be done with just one person. NA-F stated it was important to make sure R78's HOB was elevated when done with cares as he had continuous tube feed running. NA-F verified R78 had coughed a few times during cares and said that happened sometimes. NA-F was not aware of needing to turn off the tube feeding for cares and verified that was not listed on the care sheet. NA-F further stated if that was needed, the nurses would need to do that.	F0693		

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F0693 SS = D	Continued from page 34 When interviewed on 6/11/25 at 6:11 a.m., licensed practical nurse (LPN)- D verified R78 was on continuous tube feeding and stated he was tolerating the current tube feeding. LPN-D stated it was ok for R78 to lay flat during cares and there was no restriction for this. LPN-D verified the order for the tube feed to be turned off for 30-60 minutes before any cares lying flat and stated they had not noticed that order before and that was an order that typically was not done. LPN-D then stated NA staff had never asked her to pause the feeding for cares and stated she wasn't sure if R78 needed to lay flat during cares. When interviewed on 6/12/25 at 9:05 a.m., registered nurse (RN)-C stated batch orders were placed when residents had tube feeding. RN-C verified R78's order and stated she had not ever seen an order to pause tube feeding before providing cares where the resident was flat. RN-C did not believe that order should have been ordered it was not a typical order. RN-C stated pausing the feeding was to help minimize aspiration, but the time seemed to be like a long period. RN-C further stated the health unit coordinators likely clicked through them and put it in accidently. When interviewed on 6/12/25 at 1:24 p.m., the Director of Nurse (DON) expected staff to follow the orders placed for residents on tube feeding. If the orders didn't make sense, the nurse should be questioning the order. DON further stated it was her understanding staff were following the order and would need to continue to follow up with staff. A facility policy titled Enteral Tube Feeding via a continuous pump revised 3/23/23, directed staff to review the residents care plan for any special needs for the resident.	F0693		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F0700	F700 – Bedrails Immediate Corrective Action: Immediate corrective action for R74 completed grab bar assessment and was deemed appropriate for grab bars. Corrective action as it applies to others: Full house audit completed and corrected any discrepancies. Re-education with clinical leaders on Bed Rail assessment and procedure.	07/17/2025

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F0700 SS = D	Continued from page 35 elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rails were comprehensively assessed to determine if they were appropriate and safe for 1 of 2 residents (R74) who was observed to have side rails raised on their bed. Findings include: R74's admission Minimum Data Set (MDS) dated 4/2/25, indicated R74 did not use a bed rail. R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in range of motion to upper extremities, was independent with rolling left and right, moving from sitting on the side of the bed to lying flat, and moving from lying on the back to sitting on the side of the bed. Additionally, R74 took an anticoagulant (blood thinner), and did not use a bed rail. R74's Medical Diagnosis form indicated the following	F0700	Continued from page 35 Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be completed on five residents for Bed Rail Assessments completion as indicated weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	

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F0700 SS = D	Continued from page 36 diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, and long-term use of anticoagulants. R74's care plan dated 4/1/25 indicated R74 had an alteration in mobility related to weakness, confusion, urinary tract infection, Parkinson's, and ability to participate varied due to mood and cognition. Interventions included R74 required assist of 2 with movement in and out of bed and assist of 1 with transfers. R74's care plan revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care plan was reviewed and lacked information R74 had bed rails. R74's care sheet dated 6/6/25, lacked information R74 had bed rails. R74's physician's orders were reviewed and lacked information R74 had a bed rail. R74's Lift/Mobility Status form dated 3/24/25, indicated R74 could not stand, pivot, and ambulate with no or limited assistance from staff, had severe edema that limited transferring and repositioning techniques, and had Parkinson's, and unstable gait. Furthermore, the form indicated R74 required assistance with moving up in bed or turning, was not unresponsive, and required assist with lateral transfers and was a candidate for a moving aid or device. The form lacked information what type of moving aide or device R74 was a candidate for. R74's Lift/Mobility Status form dated 4/2/25, indicated	F0700		

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F0700 SS = D	Continued from page 37 R74 could stand, pivot, and ambulate with no or limited assistance from staff. The form directed staff not to proceed with the assessment if the resident could stand, pivot and walk with no or limited assistance from staff. R74's Lift/Mobility Status form dated 5/5/25, indicated R74 could stand, pivot, and ambulate with no or limited assistance from staff. The form directed staff not to proceed with the assessment if the resident could stand, pivot and walk with no or limited assistance from staff. R74's IDT Care Conference form dated 5/8/25, and locked on 6/6/25, indicated a section titled, "Positioning" and the first area instructed staff to document "Yes" "No" or "N/A" under the heading, "Positioning Device" and "N/A" was documented. Further the form indicated, to document whether a bed mobility evaluation was completed if applicable and indicated, "N/A". Additionally, the form indicated "N/A" under the section, "Team reviewed risk and benefits". R74's forms were reviewed on 6/10/25 at 2:45 p.m., and lacked information a Bed Mobility Evaluation was completed. R74's nursing progress notes were reviewed and indicated on 5/28/25 at 5:50 p.m., a nursing assistant reported a bruise on R74's inner side of right arm and the nurse asked about the cause. The progress note indicated R74 responded, "Don't ask me, I don't know when and how it happened." Further, the bruise measured approximately 4.5 inches long by 3.5 inches wide and R74 denied pain and further, staff would continue to monitor. R74's progress notes were reviewed from 3/23/25, to 6/10/25, and lacked information R74 used bed rails. During interview and observation on 6/9/25 at 6:45 p.m., R74 had a very large bruise on his right upper inner arm. The bruise was dark purple and was located on the inner side of his arm from his shoulder and extended down to just above R74's elbow. The bruise was approximately 4 inches wide. R74 stated he didn't know what he did to sustain the bruise and stated he had an inkling of what could have happened. R74 stated the	F0700		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	**28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013**

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F0700 SS = D	Continued from page 38 hospital beds have those things, R74 pointed to the hand rails on the bed and stated he had a feeling he got his arm caught in the rail and it finally came out. R74 stated he never woke up and didn't know for sure and added, what else could happen when you are laying in bed. R74 stated he could get his arm through the grab bar. R74's grab bars were up on the bed and both bars were loose. The grab bars were shaped like an upside down U with three holes inside that measured approximately 6.5 inches long by 6.5 inches wide and surveyor's arm fit through the grab bar. During interview and observation on 6/11/25 between 4:13 p.m., and 4:23 p.m., RN-A stated staff used care plans to know what cares a resident required and nurses communicate changes. RN-A further stated refusals were documented in a progress note and, in the MAR/TAR, if the refusal was a treatment or medication and nursing assistants update the nurses. RN-A stated when a resident falls, they check the resident for injuries and complete skin assessments the next few days and monitor a resident for 72 hours after a fall. RN-A stated she thought R74 fell on his right side. RN-A stated if a resident did not know how a bruise occurred, would pass the information on to a supervisor to conduct an investigation. RN-A stated bruises that were light green or yellow were older, and bruises that were red or purple were newer and further stated bruises were monitored weekly on a skin assessment and were added as a treatment in order to monitor them. RN-A viewed R74's record and verified R74's Weekly Skin Inspection form dated 6/9/25, did not mention R74's bruise to the arm. RN-A viewed the skin assessment form dated 5/25/25, that indicated R74 had a purple discoloration to his right upper arm. RN-A further viewed R74's progress note dated 5/28/25, that indicated R74 had a bruise to the inner side of the right arm that measured 4.5 inches long by 3.5 inches wide and further R74 did not know what happened. RN-A stated she documented R74 had purple discoloration but did not measure the discoloration and did not report it to another person. RN-A stated R74 told her the other night he may have reached between his rail. RN-A viewed R74's arm and stated the bruise was fading and was a purple blue in color to the inside of R74's arm. RN-A stated as far as she was aware, the provider had to order rails and an assessment needed to be completed to make sure residents are safe the use hand rails and safe to not fall through and ensure residents are capable of using bed rails. At 4:23 p.m., RN-A asked health information coordinator (HIC)-E where bed rail assessments were documented and HIC-E stated she had not seen a form itself and added they have to be in the	F0700		

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F0700 SS = D	Continued from page 39 computer. RN-A viewed R74's forms in the medical record and verified the forms lacked a Bed Mobility Device form and verified R74 had grab bars on his bed and verified the rails were loose and stated R74 should have had an assessment. During interview on 6/11/25 at 4:26 p.m., licensed practical nurse (LPN)-A stated a hand rail assessment is completed at the time a resident starts using them and assess their ability to use, to reposition and what the use if for and whether a resident ever had an issue or became entangled and stated it was a whole assessment to prove a resident can use a bed rail and what had been tried previously. LPN-A stated the form was under forms in the computer, called a bed mobility device and then the rails were placed by maintenance and maintenance has a measurement. LPN-A stated the send a Tels and then maintenance applies the bed rails. During interview on 6/11/25 at 4:59 p.m., LPN-A stated she expected staff document the bruise. LPN-A goes over progress notes in the a.m., and if she finds a progress note of the skin they try to figure out where it came from. LPN-A further stated if staff find a bruise and it is not documented on admit and staff do not know, it needs to be documented or they need to tell someone. LPN-A further stated she or others will complete an investigation and findings should be in a progress note and further stated monitoring should be on the TAR. LPN-A stated she was not aware R74 had a bruise and asked where the bruise was located and stated she would have to check. LPN-A verified R74 had a progress note dated 5/28/25, that indicated R74 had a bruise and resident did not know what happened. LPN-A viewed R74's orders and verified there were no orders for monitoring R74's bruise. LPN-A viewed R74's incidents and verified there was no investigation conducted. LPN-A stated she did not know how she missed that one. LPN-A stated R74 could remember some things and was better when his wife was at the facility. LPN-A verified R74 had a bruise on his right inner arm and R74 stated the only thing he could figure out was that his arm was in one of those brackets and pointed to the bed rail and LPN-A asked R74 if she could measure the bruise. LPN-A viewed R74's electronic medical record (EMR) and verified the EMR lacked information a bed rail assessment was completed. LPN-A stated if there was a hint the bruise could have been caused by the rail, the rail was coming off and would have to get maintenance. LPN-A viewed R74's bed and stated it was not their normal bed and verified the rail was loose.	F0700		

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F0700 SS = D	Continued from page 40 During interview on 6/11/25 at 5:25 p.m., LPN-A later stated she and the director of nursing (DON) went back through the morning stand up meeting note on 5/28/25, and stated the investigation was completed and R74's bruise was likely due to hitting his arm on on the wheelchair and R74 repositioned self a lot with his arms and stated R74 should have had monitoring in place. A copy of the interdisciplinary team (IDT) note was requested. Further, LPN-A stated R74 should have had an assessment with the bed rails and stated the bed comes with the rails and was their bed, just not the normal bed R74 used and stated R74 normally didn't have bed rails and stated she planned to get the rails off. A form, Bed Mobility Device Evaluation, was later added by the director of nursing (DON) on 6/11/25 at 5:41 p.m., and locked at 5:48 p.m., that indicated R74 requested a bed mobility device and 1/4 grab bars bilaterally were preferred. The form indicated R74 had not attempted to get out of bed by climbing over and around a bed mobility device in the past quarter, had not sustained bruises, skin tears, lacerations or fractures from a bed mobility device within the past quarter, had not become entangled in a bed mobility device or entrapped between the mattress and bed mobility device. Further, the form indicated R74 used the device to assist with transfers, used the device to assist with repositioning in bed, could demonstrate proper use, under a heading, "Have alternatives been attempted prior to placement of assist" indicated options to document "Yes", "No" or "N/A". "N/A" was documented. Further, R74 and R74's representative was informed regarding the risks and benefits of a bed mobility device and gave consent. During interview on 6/12/25 at 8:49 a.m., with the administrator and LPN-A, LPN-A stated R74's bruise measured 24 centimeters (CM) by 7 cm (approximately 9.4 inches by 2.7 inches) and further stated they updated the physician the bruise increased in size and an INR and ultrasound was ordered. The IDT report was again requested and the administrator stated she would pull that information. The administrator stated if an injury was identified, the director of nursing and administrator are notified at standup or if out side that period are notified of a bruise by the nurse or nurse manager and investigate by asking the resident if they know if anyone hurt them, whether they feel safe, observe transfers, mobility and if bumping into edges and stated R74 leans over and grabs things. Once a bruise is identified the family, provider, are notified	F0700		

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F0700 SS = D	Continued from page 41 and monitoring orders are placed and the provider may provide additional orders and would have expected the bruise to be monitored in the medical record. Both the administrator and LPN-A stated R74's bed rail assessment was completed on 6/11/25 and the administrator stated the nurse or nurse manager completes a bed rail assessment and deems it safe to use and updates the party and places a communication in Tels for maintenance to apply the rails on the bed and then reassessments were completed quarterly. The administrator stated R74 had a new bed and maintenance makes sure the rails are secure and R74's would have been with the initial use. The administrator stated she couldn't confirm whether someone completed a form on paper and did not put it in the EMR. The administrator further stated if done on paper expected the form be uploaded and would be put into the chart in the electronic form and would be completed with the initiation of use. The administrator stated it was important to make sure residents were safe, they are able to understand the risk of the bed rail, and identify if it was a risk for entrapment and that the rail is appropriate for use and that the facility involves the responsible party. The administrator stated R74 had the same bed rail from yesterday. The administrator further stated she had to see if R74 had a recent bed change and was not aware he had a bed change. The maintenance Tels logs were requested and a policy on bed rail assessments. A Tels report dated 3/12/25, to 6/12/25, was provided on 6/12/25 at 11:28 a.m., that lacked information maintenance applied bed rails. During interview on 6/12/25 between 11:28 a.m., and 11:39 a.m., the administrator stated there wouldn't be a Tels because the bed already had the grab bars attached and were built into the frame and further stated the grab bars go up and down and could not determine when the rails were put up and stated they only had four or five beds like this and would be zip tied in the down position. The administrator stated the grab bars could not be removed and therefore would not be a Tels. The administrator stated most of these types of beds were located on the transitional care unit and cannot identify who put the rails up and stated staff communicate well and know the policy and they have an assessment for everyone and would ask the nurse if they noticed a bed rail. The administrator stated maintenance checked the beds for rails every day and every month for looseness and don't know how long R74 had the bed. The administrator verified the rail was	F0700		

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F0700 SS = D	Continued from page 42 loose and wiggling at 11:39 a.m. During interview on 6/12/25 at 12:00 p.m., the administrator stated the rail was welded to the bed and was spring loaded to move the rails up and down but there was no way to make the rail tighter. No additional information was provided. A procedure, Clinical Bed Mobility Device Procedure, undated indicated a bed mobility device is any device or equipment that is permanently affixed to the bed, or the resident is unable to remove independently. The purpose of such device is to allow residents to achieve their highest level of physical and psychosocial wellbeing. Bed Mobility Device form should be completed on implementation, quarterly and with any significant change. Review the following included the Bed Mobility Device form before implementing: review of resident responsible party preferences for bed mobility devices, complete fall injury risk determination, complete mobility assessment, evaluation of alternatives, address bed mobility device to be used, and contact responsible party for informed consent.	F0700		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary Immediate Corrective Action: Immediate corrective action was to throw away all items held in kitchenette on unit and deep clean/sanitization by housekeeping. Corrective action as it applies to others: Re-education with staff regarding appropriate notification via TELS when maintenance or housekeeping concern. Date of Compliance: 6/12/25 Recurrence will be prevented by: Audits will be completed of long-term care kitchenettes for cleanliness weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Culinary Director/Designee	06/12/2025

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F0812 SS = D	Continued from page 43 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper cleaning for 1 of 3 unit kitchenettes. During observation on 6/11/25 at 7:19 a.m., a drawer had a sign in it, "DO NOT PUT STUFF IN THIS DRAWER MICE POOP IN IT." There were small brown pellets observed in drawer and one unopened tea bag. In a cupboard above the sink there was an empty baggie with a stuck on single serving strawberry jelly package lid. Also, white powder substance on shelf under the containers holding condiments in them. During interview on 6/11/25 at 7:29 a.m., nursing assistant (NA)-A stated there was a note that read, "DO NOT PUT STUFF IN THIS DRAWER MICE POOP IN IT." NA-A reported seeing turds, black/brown and little, and one tea bag. In the cupboard I see containers with stuff in them, behind it a baggie with stuck on jelly, sorry, and threw item in the garbage. Stated they did not know who oversaw cleaning the unit kitchenettes, but kitchen staff stocks them. During interview on 6/11/25 at 7:38 a.m., environmental services (EVS)-A stated they clean unit kitchenettes, unaware of any cleaning issues in drawers or cupboards. During interview on 6/11/25 at 8:46 a.m., EVS-B stated they clean the top of paper towel machine, counters, soap dispensers and take out the garbage. Stated was unaware of which department oversees cleaning cupboards and drawers in the unit kitchenettes. EVS-B opened drawer and stated it was nasty, there was mouse poop, one tea bag and a letter stated, "DO NOT PUT STUFF IN THIS DRAWER MICE POOP IN IT." During interview on 6/11/25 at 8:59 a.m., culinary director (CB)-B stated they stock items in kitchenettes once a week, no deep cleaning logs. Note from drawer found in trash, and drawer was cleaned. Note was retrieved from garbage, brought to the administrator-A.	F0812		

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F0812 SS = D	Continued from page 44 During interview on 6/11/25 at 9:07 a.m., with EVS-D, administrator-A, CB-B met and informed of the situation in the unit kitchenette. EVS-D stated there was not a deep cleaning schedule for the kitchenettes, the expectation of the kitchenettes was to be clean and mice dropping free. Administrator-A stated if there was a concern for this type of issues, no food or storage should be in these areas. Currently, there was not a deep cleaning log. During interview on 6/11/25 at 1:56 p.m., with nursing assistants (NA)- C and NA-D stated did not see any signs of mice or pests. If seen, would inform maintenance and nurse manager immediately. There was not a facility policy regarding the cleaning schedule for the unit kitchenettes. There were facility logs from Plunkett's pest control, on schedule of treatments, interventions and the pest control program.	F0812		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all	F0842	F842 – Resident Records – Identifiable Information Immediate Corrective Action: Immediate corrective action for R74 included assessment and monitoring orders for bruises. Corrective action as it applies to others: Re-education will be provided to clinical leaders regarding need to assess and document on an Injury of Unknown Origin weekly. Facility wide audit of weekly skin checks and followed up with any identified discrepancies. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be completed on five residents for Weekly Skin Checks to ensure completion weekly x4 and then monthly for x2. Discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	07/17/2025

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F0842 SS = E	Continued from page 45 information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F0842		

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F0842 SS = E	Continued from page 46 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident medical records were complete, accurately documented, and readily accessible for 1 of 1 residents (R74) reviewed. Findings include: According to the State Operations Manual (SOM) dated 4/25/25, an injury should be classified as an "injury of unknown source" when all of the following criteria are met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because: a. the extent of the injury, or b. the location of the injury i.e. the injury is located in an area not generally vulnerable to trauma, or the number of injuries observed at one particular point in time, or the incidence of injuries over time. Further, the SOM breaks down injuries that are required to report that include unobserved/unexplained scratches and bruises found in suspicious locations such as the head, neck, upper chest or back, unobserved/unexplained patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object, unobserved/unexplained bilateral bruising to arms, bilateral bruising of the inner thighs, "wrap around" bruises that encircle the legs, arms or torso, and multicolored bruises which would indicate that several injuries were acquired over time, and unobserved/unexplained bruising or other injuries in the genital area, inner thighs, or breasts. Furthermore, injuries not required to report included bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect, injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect, injuries that were witnessed by staff, where there is no indication of abuse or neglect. Additionally, the SOM indicated even if the injury is not one that requires a report, the facility should adequately assess and monitor the resident, notify the physician/resident representative as appropriate, and document the injury and investigation as a part of the resident's medical record.	F0842		

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F0842 SS = E	Continued from page 47 See also F684 F74: R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in range of motion to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. Additionally, R74 took an anticoagulant (blood thinner), and did not use a bed rail. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, and long-term use of anticoagulants. R74's care plan dated 4/1/25, indicated R74 had a self-care deficit related to confusion, urinary tract infection, catheter use, and required assist of one with bathing, dressing, and personal hygiene. R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care sheet dated 6/6/25, indicated R74 was on	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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F0842 SS = E	Continued from page 48 anticoagulants, but lacked information R74 had a bruise. R74's Physician Orders form indicated the following orders: • 3/28/25, weekly skin inspection by licensed nurse every Friday evening shift. Complete the weekly skin inspection in PCC. • 6/3/25, Warfarin (a blood thinner) 1.5 milligram (MG) by mouth every Monday, Tuesday, Wednesday, and Friday at HS (hour of sleep) until 6/16/25. • 6/5/25, Warfarin 1 mg by mouth every Thursday, Saturday, and Sunday at HS until 6/16/25. • 6/8/25, make a progress note post fall for 72 hours. Make sure to include any signs or symptoms of injury and effectiveness of new fall interventions. • 6/8/25, monitor for signs and symptoms of injury post fall for 72 hours every shift for three days. • R74's orders lacked direction for monitoring or assessing the bruise to R74's inner side of right arm identified in the nursing progress notes on 5/28/25. R74's medication administration record (MAR) and treatment administration record (TAR) for May 2025, indicated R74 had a weekly skin inspection on 5/2/25, 5/9/25, 5/16/25, 5/23/25, and 5/30/25. Further, the MAR/TAR lacked direction to monitor or assess R74's bruise to the inner side of the right arm identified on	F0842		

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F0842 SS = E	Continued from page 49 5/28/25. R74's MAR/TAR for June 2025, indicated R74 had a weekly skin inspection on 6/6/25. Additionally, the MAR/TAR indicated staff documented 6/8/25, and 6/9/25, they monitored for signs and symptoms of injury post fall. The MAR/TAR lacked documentation R74's bruise to the inner side of the right arm identified on 5/28/25, was monitored or assessed. R74's nursing progress notes were reviewed and indicated on 5/28/25 at 5:50 p.m., a nursing assistant reported a bruise on R74's inner side of right arm and the nurse asked about the cause. The progress note indicated R74 responded, "Don't ask me, I don't know when and how it happened." Further, the bruise measured approximately 4.5 inches long by 3.5 inches wide and R74 denied pain and further, staff would continue to monitor. Further, the note lacked information an investigation was completed to determine the cause, or if the physician, or resident representative was notified. R74's nursing progress notes dated 6/7/25, indicated R74 was observed falling and hitting his head on the wall. R74 reported his right knee went out and got caught when turning. Under a heading, "Nursing assessment for s/s [signs and symptoms] or pain and/or injury:" indicated R74 had redness to his posterior scalp, and reported right knee discomfort. The note lacked information regarding R74's bruise to his right inner arm. R74's nursing progress notes dated 6/9/25, indicated R74 had a small abrasion to the right knee. The progress notes lacked information regarding R74's bruise to his right inner arm. R74's nursing progress note dated 6/10/25 at 4:25 a.m., indicated R74 had no new injuries related to a recent fall. R74's Weekly Skin Inspection form dated on 5/25/25, and locked on 5/26/25, documented by registered nurse (RN)-A indicated R74 had redness to the groin area, additionally, R74 had purple discoloration to the right upper arm and had no complaints of pain. The note lacked documentation of the size of the discoloration,	F0842		

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F0842 SS = E	Continued from page 50 where on the upper arm the discoloration was, or how R74 obtained the purple discoloration. R74's Weekly Skin Inspection form dated and locked on 5/30/25, indicated R74's skin was clean, dry, and intact and had a pink area to the groin and powder was applied. The form lacked documentation regarding the purple discoloration to the right upper arm, and lacked documentation regarding the bruise identified on 5/28/25 to the inner side of right arm. R74's Weekly Skin Inspection form dated and locked on 6/9/25, indicated R74's groin was slightly pink with no open areas and treatment was in place. Further, the note indicated R74 had a pink area to the top of his head from a fall and was not open. The form lacked documentation regarding the purple discoloration to the right upper arm, and lacked documentation regarding the bruise identified on 5/28/25 to the inner side of right arm. During interview and observation on 6/9/25 at 6:45 p.m., R74 had a very large bruise on his right upper inner arm. The bruise was dark purple and was located on the inner side of his arm from his shoulder and extended down to just above R74's elbow. The bruise was approximately 4 inches wide. R74 stated he didn't know what he did to sustain the bruise and stated he had an inkling of what could have happened. R74 stated the hospital beds have those things, R74 pointed to the hand rails on the bed and stated he had a feeling he got his arm caught in the rail and it finally came out. R74 stated he never woke up and didn't know for sure and added, what else could happen when you are laying in bed. During observation on 6/11/25 at 8:53 a.m., R74 was in his wheelchair and his arms were on the inside of the wheelchair resting in his lap. At 8:57 a.m., R74 propelled himself out of his room and his right and left arms were on the arm rests of the wheelchair from wrist to elbow. Did not observe R74 bumping into anything. During interview on 6/11/25 at 10:02 a.m., nursing assistant (NA)-A stated she cared for R74 today and provided R74 a wash cloth and further stated she assists R74 with dressing adding, she got R74's clothes out of the closet and helped donn R74's shirt and	F0842		

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F0842 SS = E	Continued from page 51 stated R74 could put his arms thru the sleeves. NA-A stated R74 did not refuse cares. NA-A stated she would have to report findings of bruises, scratches, and reddened areas. During interview and observation on 6/11/25 at 4:13 p.m., RN-A stated staff used care plans to know what cares a resident required and nurses communicate changes. RN-A further stated refusals were documented in a progress note and in the MAR/TAR if the refusal was a treatment or medication and nursing assistants update the nurses. RN-A stated when a resident falls, they check the resident for injuries and complete skin assessments the next few days and monitor a resident for 72 hours after a fall. RN-A stated she thought R74 fell on his right side. RN-A stated if a resident did not know how a bruise occurred, would pass the information on to a supervisor to conduct an investigation. RN-A stated bruises that were light green or yellow were older, and bruises that were red or purple were newer and further stated bruises were monitored weekly on a skin assessment and were added as a treatment in order to monitor them. RN-A viewed R74's record and verified R74's Weekly Skin Inspection form dated 6/9/25, did not mention R74's bruise to the arm. RN-A viewed the skin assessment form dated 5/25/25, that indicated R74 had a purple discoloration to his right upper arm. RN-A further viewed R74's progress note dated 5/28/25, that indicated R74 had a bruise to the inner side of the right arm that measured 4.5 inches long by 3.5 inches wide and further R74 did not know what happened. RN-A stated she documented R74 had purple discoloration but did not measure the discoloration and did not report it to another person. RN-A stated R74 told her the other night he may have reached between his rail. RN-A viewed R74's arm and stated the bruise was fading and was a purple blue in color to the inside of R74's arm. During interview on 6/11/25 at 4:59 p.m., LPN-A stated she expected staff document the bruise. LPN-A goes over progress notes in the a.m., and if she finds a progress note of the skin they try to figure out where it came from. LPN-A further stated if staff find a bruise and it is not documented on admit and staff do not know, it needs to be documented or they need to tell someone. LPN-A further stated she or others will complete an investigation and findings should be in a progress note and further stated monitoring should be on the TAR. LPN-A stated she was not aware R74 had a bruise and asked where the bruise was located and stated she would have to check. LPN-A verified R74 had a progress note	F0842		

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F0842 SS = E	Continued from page 52 dated 5/28/25, that indicated R74 had a bruise and resident did not know what happened. LPN-A viewed R74's orders and verified there were no orders for monitoring R74's bruise. LPN-A viewed R74's incidents and verified there was no investigation conducted. LPN-A stated she did not know how she missed that one. LPN-A stated R74 could remember some things and was better when his wife was at the facility. LPN-A verified R74 had a bruise on his right inner arm and R74 stated the only thing he could figure out was that his arm was in one of those brackets and pointed to the bed rail and LPN-A asked R74 if she could measure the bruise. During interview on 6/11/25 at 5:25 p.m., LPN-A later stated she went back through the morning stand up meeting note on 5/28/25, and stated the investigation was completed and R74's bruise was likely due to hitting his arm on the wheelchair and R74 repositioned self a lot with his arms and stated R74 should have had monitoring in place. A copy of the interdisciplinary team (IDT) note was requested. A progress note was later added by LPN-A on 6/11/25 at 6:01 p.m., that indicated R74's bruising was reviewed in IDT on 5/28 and was determined through investigation and observation R47 was leaning over to get something off the floor and bruising was from the wheelchair arm. Further the bruising was purple, diffused with faded edges and measured 24 by 7 and monitoring orders were placed. The note further indicated R74 felt safe and no one harmed him. Additionally, the note indicated the provider was updated on the increased size of the bruise who provided a telephone order for daily measurements, ultrasound, and a new INR (International Normalized Ratio, a lab that measures how long it takes for blood to clot). During interview on 6/12/25 at 8:49 a.m., with the administrator and LPN-A, LPN-A stated R74's bruise measured 24 centimeters (CM) by 7 cm (approximately 9.4 inches by 2.7 inches) and further stated they updated the physician the bruise increased in size and an INR and ultrasound was ordered. The IDT report was again requested and the administrator stated she would pull that information. The administrator stated if an injury was identified, the director of nursing and administrator are notified at standup or if out side that period are notified of a bruise by the nurse or nurse manager and investigate by asking the resident if they know if anyone hurt them, whether they feel safe, observe transfers, mobility and if bumping into edges	F0842		

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F0842 SS = E	Continued from page 53 and stated R74 leans over and grabs things. Once a bruise is identified the family, provider, are notified and monitoring orders are placed and the provider may provide additional orders and would have expected the bruise to be monitored in the medical record. Both the administrator and LPN-A agreed it should have been in the medical record for staff to be able to further assess. An email sent by the administrator on 6/12/25 at 9:23 a.m., contained a PDF document titled, "5.28 stand up skin". The form indicated, "Wound-Skin Concerns" at the top and was highlighted in yellow. The form contained a section for names, skin concerns, and progress. R74's skin concern indicated R74 had a bruise to the right upper extremity that was new from hitting the wheelchair. An additional PDF document titled, "5.28 24-hour" was also provided that indicated R74 had a bruise on the inner side of the right arm that included measurements 4.5 by 2.5 from hitting on wheelchair per investigation and observation. During interview on 6/12/25 at 9:26 a.m., family member (FM)-A stated she wasn't sure how R74 got the bruise and wondered if R74 got stuck on the thing inside of the bed or if R74 leaned over the side of the wheelchair and thought it was either due to the side rail of the bed or leaning over. FM-A stated she had received more than a call on the bruise and stated the facility tried to figure out how it happened, but didn't think it was on 6/11/25. A policy, Abstract of Medical Records, revised December 2006, indicated survey tag numbers F583, and F842. The policy indicated specific data concerning a resident's medical condition may be released when the resident is transferred to a hospital or other health-related institution and an abstract of the resident's medical record may be made when the resident is transferred to a hospital or other health-related facility. The policy lacked information regarding the facility ensuring the medical record was maintained on each resident that was complete; accurately documented; and readily accessible.	F0842		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	F880 – Infection Prevention & Control Immediate Corrective Action: Education for all nursing and therapy staff will be provided on hand hygiene, also specifically for	07/17/2025

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F0880 SS = F	Continued from page 54 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 54 Transmission Based Precautions (TBP) for R2, R192, and R78. Corrective action and re-education were provided for staff. Immediate corrective action for R78 to be added to the infection surveillance log. Corrective action as it applies to others: Infection surveillance log reviewed, and discrepancies corrected. Reviewed Transmission Based Precautions, Hand Hygiene, and Infection Prevention and Control Program and remain current. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be completed on five residents on TBP to ensure staff are following precautions and completing hand hygiene appropriately weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Audits will be completed on five residents to ensure they are on the surveillance log weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	

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F0880 SS = F	Continued from page 55 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: R192 R192's admission Minimum Data Set (MDS) dated 6/2/25, indicated R192 was cognitively impaired and had diagnoses of peripheral vascular disease (PVD) and non-pressure chronic ulcers of the feet. R192 had 5 venous ulcers that required dressing changes. R192's provider order dated 6/9/25, indicated R192 required staff to follow contact precautions for MRSA infection in their wounds. An observation on 6/10/25 at 1:37 p.m., licensed practical nurse (LPN)-F pushed R192 into his room. On the door of the room was a sign that stated contact precautions. The sign instructed staff to don gown and gloves before entering the room. LPN-F got R192 situated in their room then exited, performed hand hygiene and donned a gown and gloves before re-entering the room. While gowning up, LPN-F stated she didn't understand why R192 could be outside of the room while on contact precautions and it didn't makes sense to them. Once entering the room, LPN-F gathered supplies. R192 remained in their wheelchair told LPN-F he thought he could help and lift their legs. LPN-F cut and removed R192's left leg dressing first. The wounds were cleaned per orders. Calcium algenate dressing was then removed from it's wrapper and cut to fit the wounds for	F0880		

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F0880 SS = F	Continued from page 56 the left foot. LPN-F then removed gloves to look through a box of supplies for a measure tape without any gloves on. A tape was not found, so LPN-F removed her gown and performed hand hygiene as they left the room to obtain measure tape. LPN-F entered the room again with a gown on, but no gloves. Placed the tape on the side table and then without hand hygiene, donned gloves. The wound was washed again as ordered and measured. LPN-H removed gloves and without hand hygiene, placed new gloves and placed the calcium alginate into the wound beds, placed gauze over the calcium alginate and then wrapped in kerlix. LPN-H removed gloves and again went in the box of wound care supplies and found tape. The kerlix was taped down. Without hand hygiene, LPN-F new gloves were placed and a clean sock placed on R192's left foot. LPN-F then removed the sock of the right foot and used the scissors to cut the kerlix on the right foot. LPN-F removed gloves and stopped to re-tie gown. Without hand hygiene, new gloves were placed and finished cutting off the kerlix and removed the remaining gauze and dressing. After exposing the wounds, gloves were removed and without hand hygiene, new gloves placed. LPN-F cleansed the wounds per order. Gloves were removed and without hand hygiene, obtained calcium alginate and placed on wounds. Gauze was then placed and R192's leg was wrapped in kerlix. LPN-F finished cleaning up, removed gown and gloves and performed hand hygiene upon exit of 192's room. When interviewed on 6/10/25 at 2:20 p.m., LPN-F verified she should have been performing hand hygiene in between glove exchanges and should have had gloves in place when looking through the wound supplies in the room. LPN-F stated it was a busy shift, and she wanted to work quickly as R192 was holding his legs up for the dressing changes and thought glove changes would be ok in this situation. R78 R78's admission Minimum Data Set (MDS) dated 5/15/25, indicated R78 had severely impaired cognition and diagnoses of stroke with right sided paralysis. R78 required substantial staff assist with bed mobility and was dependent on staff for toileting cares. R78's provider orders showed the following:	F0880		

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F0880 SS = F	Continued from page 57 -on 5/23/25, R78 required a stool sample to rule out C.Diff infection. -on 5/26/25, R78 required Vancomycin oral suspension (antibiotic) 50 milligrams (mg)/milliliter (ml) 2.5ml via gastrostomy tube every 6 hours for C.Diff for 10 days. -on 6/4/25, indicated R78 required staff to follow contact precautions-enteric. R78's care plan dated 5/12/25, indicated R78 had a self-care deficit, and staff were to assist with personal hygiene. R78 further required enhanced barrier precautions (EBP) related to a gastrostomy tube (G-tube). A facility document titled Infection Log dated 6/2025, indicated R78 had C. Diff with symptoms of loose stool. There was no onset date listed. The log indicated R78 had completed 4 days of antibiotic therapy until 6/6/25. The log lacked indication of R78 improving with the antibiotic or if symptoms of loose stools remained. when returning from the hospital on 6/onset of MRSA cellulitis (skin infection) on 3/9/25 and was started on Doxycycline. There was no antibiotic end date listed. A facility document titled Infection Log dated 5/2025, did not include R78 as a resident with suspicion of C. Diff, had tested positive for C. Diff, or had been started on antibiotics for C. Diff. An observation on 6/11/25 at 7:58 a.m., NA-F performed hand hygiene, donned a gown and gloves before entering R78's room for cares. On the outside of R78's door was a sign that read Enteric Contact Precautions. The sign instructed staff to gown and glove when entering room and to wash hands upon exit. NA-F greeted the resident who was sleepy and asked to check for incontinence and reposition. NA-F lowered R78's s head of bed and assisted to roll on their right side. R78 had a soiled brief and needed to be cleaned up. NA-F assisted R78 back onto his back and obtained some supplies from R78's bathroom. NA-F unfastened R78 brief from the front and completed front perianal cares and catheter	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	**28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013**

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F0880 SS = F	Continued from page 58 care. NA-F then assisted R78 to roll onto their right side and rolled the soiled brief. NA-F then performed perianal cares from the back and then pulled out the rolled soiled brief and placed in a garbage bag. NA-F then removed gloves and without hand hygiene, donned a new pair. Barrier cream was obtained and placed on R78's bottom. NA-F then removed the left hand glove and without hand hygiene placed another one on. A clean brief was then tucked under R78 and NA-F assisted R78 to roll from side to side and secure it. R78 declined to be further repositioned in bed. NA-F raised R78's HOB and straightened the room before removing gown and gloves and washing hands. When interviewed on 6/11/25 at 8:23 a.m., NA-F acknowledged they had not performed hand hygiene in between glove changes and had not instructed to do that in the past. NA-F stated it also would have increased the time to lower the bed and then go to the hand sanitizer, come back and raise the bed to continue cares. When interviewed on 6/10/25 at 3:29 p.m., RN-C expected staff to wear gown and gloves when entering any room on contact isolation. Furthermore, RN-C expected staff to wear gloves when in contact with a resident's items and in between glove changes. When interviewed on 6/12/25 at 1:58 p.m., the infection preventionist (IP) stated when there was a concern for an infection from residents, they were added to the infection log. This information would be brought up from staff to leaders or discussed in morning meetings. Then it is determined if testing or isolation was needed and then added to the infection log. When asked to review R78's C. Diff infection, IP stated he had came back from the hospital with it. IP was not aware R78 was tested prior and started on antibiotics prior to their hospital leave. IP further verified R78's infection was not tracked on the infection log and wasn't sure if R78 was still having any symptoms. When reviewing the infection logs, there was not any follow up for residents listed if their symptoms and/or infection had resolved. IP stated ideally, all that information would be tracked. IP expected staff to adhere to any TBP that were posted and perform hand hygiene between glove exchanges. This was important to help minimize the spread of infections and to help track infections spreading in the facility.	F0880		

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F0880 SS = F	Continued from page 59 A facility policy titled Handwashing Policy revised 2/2024, directed staff to wash hands before conducting a procedure that require gloves and after the removal of gloves. A facility policy titled Transmission Based Precautions revised 7/31/23, directed staff to utilize TBP for residents who are known to be or are suspected of being infected with an infectious agent. A facility policy titled Infection Prevention and Control Program revised directed staff to use surveillance tools to recognize the occurrence of infections, the number and frequency to help detect outbreaks. The surveillance will be reviewed monthly for trends or significant problems since the previous review. Based on observation, interview and document review the facility failed to ensure transmission-based precautions (TBP) was maintained for 1 of 1 residents (R2) observed during a transfer and for 1 of 1 residents (R192) who was observed for wound care. Furthermore, the facility failed to ensure hand hygiene was maintained for 2 of 2 residents (R192, R78) observed during cares. Furthermore, the facility failed to ensure their infection surveillance process was implemented when R78 has suspicion of Clostridioides difficile (C. Diff, a highly contagious communicable disease) and tested positive while in the facility. This had the potential to impact all residents who reside in the facility. Findings include: R2 R2's admission Minimum Data Set (MDS) dated 5/16/25, indicated moderately impaired cognition and diagnoses of Methicillin Resistant Staphylococcus Aureus Infection (MRSA), cellulitis of the buttock, pressure ulcer of left buttock, and Extended Spectrum Beta Lactamase (ESBL) resistance. It further indicated R9 had bilateral impairment to the upper extremities (UE), was dependent on staff for mobility, was always incontinent of bowel and bladder, and had a stage III pressure ulcer.	F0880		

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F0880 SS = F	Continued from page 60 During observation on 6/10/25 at 1:42 p.m., R2 was sitting in his room in his wheelchair, he put on his call light and NA-E anwered it, asking him if he wanted to lay down. He responded yes, and NA-E exited the room. At 1:47 p.m., NA-E came back with a package of briefs, entered R2's room and set them down, went out into the hallway, grabbed the EZ stand lift, and went back into the room and shut the door. NA-E did not put on a gown or gloves before entering the room. At 1:50 p.m., NA-E exited the room and put the EZ stand lift back out in the hallway. R2 was laying in bed. During interview on 6/10/25 at 1:53 p.m., NA-E verified the sign on R2's door indicated he was on contact precautions and stated she was told staff should wear a gown and a mask when entering R2's room but she didn't because "he wasn't wet and didn't need to be changed." During interview on 6/10/25 at 2:04 p.m., registered nurse (RN)-B stated staff should be wearing a gown and gloves when they are in direct contact with the resident and/or their body fluids when a resident was on contact precautions. Some examples of these types of cares were assisting a resident to go to bed, transferring them, and changing their linens. During interview on 6/11/25 at 9:50 a.m., nursing assistant (NA)-D stated staff should be wearing a gown and gloves upon entering a residents room who was on contact precautions. During interview on 6/11/25 at 9:54 a.m., licensed practical nurse (LPN)-B stated staff should wear a gown and gloves when performing cares for a resident on contact precautions. During interview on 6/12/25 at 3:16 p.m., the Director of Nursing (DON) stated staff should be wearing a gown and gloves when performing cares for a resident who was on contact precautions. If staff aren't wearing the appropriate PPE, there was an increased risk in spreading illnesses throughout the facility (with anyone those staff come into contact with).	F0880		
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F0881	F881 – Antibiotic Stewardship Program Immediate Corrective Action: Immediate corrective action for R28 added to infection surveillance log and	07/17/2025

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F0881 SS = F	Continued from page 61 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement their antibiotic stewardship program and ensure antibiotic use was tracked, monitored and appropriate for 1 of 1 residents (R28) who was prescribed an antibiotic. Findings include: R28's significant change Minimum Data Set (MDS) dated 5/17/25, indicated severely impaired cognition, had a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA), and received an antibiotic on a routine basis. R28's physician's orders dated 3/11/25 indicated Doxycycline Monohydrate 100 milligram (mg) capsule. Give 1 capsule by mouth two times a day related to MRSA as the cause of diseases classified elsewhere. No current stop date due to awaiting an appointment to be scheduled per infectious disease (ID). R28's care plan dated 2/14/25, indicated R28 was on contact precautions for MRSA. Infection control precautions per protocol with the following interventions: -sign on resident's door -treatment for current infection per order R28's Medication Administration Record (MAR) for the months of March 2025-June 2025, indicated R28 starting taking Doxycycline on 3/11/25 and was still taking it currently (as of 6/12/25).	F0881	Continued from page 61 end date for antibiotic clarified. Corrective action as it applies to others: Infection surveillance log reviewed, and discrepancies corrected. Education to clinical leaders regarding Antibiotic Stewardship Program. The Antibiotic Stewardship Program Policy was reviewed and remains current. Like-resident audited for antibiotic stop dates. Date of Compliance: 7/17/25 Recurrence will be prevented by: Audits will be completed weekly on five residents to ensure they are on the infection surveillance log as needed with appropriate stop dates weekly x4 and then monthly for x2, discrepancies will be corrected immediately when identified in audits. Reeducation will be provided as needed to ensure compliance. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing/Designee	

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F0881 SS = F	Continued from page 62 A facility document titled Infection Log dated 3/2025-6/2025, indicated R28 had an onset of MRSA cellulitis (skin infection) on 3/9/25 and was started on Doxycycline. There was no antibiotic end date listed. The document did not indicate R28 had continued to be prescribed the doxycycline for the months of 4/2025-6/2025. An interview on 6/12/25 at 1:58 p.m., the infection preventionist (IP) stated when there was a potential or known infection for a resident the information was added to the Infection logs. If an antibiotic was ordered that information was also tracked. Tracking included orders to monitor for symptoms, ensuring there was an end date, and ensuring the infection was resolved, IP verified R28's antibiotic was started in 3/2025 and at that time there wasn't an end date listed. IP wasn't sure why R28 was still on the antibiotic and verified it had not been tracked for the months of 4/2025-6/2025. IP stated if the order had been changed to prophylaxis or had changed to include an end date, it would have triggered as a new antibiotic order and been noted on the reports. Since the order had not changed at all, there wasn't the prompt to continue tracking it on the infection log. IP stated it should have been included on the logs and that may have prompted follow up to understand if R28 still needed to be on the antibiotic. A facility policy titled Antibiotic Stewardship Program revised 3/13/23, directed staff to ensure all antibiotics included a duration of treatment (start and end date). The IP or designee will review all antibiotic orders for appropriateness of treatment and if not appropriate, notification to the provider. The IP and consulting pharmacist will monitor antibiotic use tracking through a infection/antibiotic tracking form.	F0881		

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K0000	INITIAL COMMENTS An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/10/2025. 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. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke	K0000		

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K0000	Continued from page 2 detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0911 SS = F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, and 5.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 at 11:00 AM, it was revealed by observation that a remote emergency stop button found for the emergency generator was located inside the locked generator room and was not accessible. An interview with Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K0911	K911 Electrical Systems Remote Emergency Stop was installed for generator in an accessible location for all staff, date of compliance 7/3/25. During routine generator checks, the Maintenance Director or Designee will verify functionality. Corrections will be monitored by: Maintenance Director/Designee	07/03/2025

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 1, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: EQO811

Dear Administrator:

The above facility was surveyed on June 9, 2025 through June 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/9/25-6/12/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H53286468C (MN00110393) H53284208C (MN00112603). no citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.	20000		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission;	20625	Corrected	07/17/2025

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20625	Continued from page 2 B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and	20625		

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20625	Continued from page 3 P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident medical records were complete, accurately documented, and readily accessible for 1 of 1 residents (R74) reviewed. Findings include: According to the State Operations Manual (SOM) dated 4/25/25, an injury should be classified as an "injury of unknown source" when all of the following criteria are met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because: a. the extent of the injury, or b. the location of the injury i.e. the injury is located in an area not generally vulnerable to trauma, or the number of injuries observed at one particular point in time, or the incidence of injuries over time. Further, the SOM breaks down injuries that are required to report that include unobserved/unexplained scratches and bruises found in suspicious locations such as the head, neck, upper chest or back, unobserved/unexplained patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object, unobserved/unexplained bilateral bruising to arms, bilateral bruising of the inner thighs, "wrap around" bruises that encircle the legs, arms or torso, and multicolored bruises which would indicate that several injuries were acquired over time, and unobserved/unexplained bruising or other injuries in the genital area, inner thighs, or breasts. Furthermore, injuries not required to report included bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect, injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect, injuries that were witnessed by staff, where there is no indication of abuse or neglect. Additionally, the SOM indicated even if the injury is not one that requires a report, the facility should adequately assess and monitor the resident, notify the physician/resident representative as appropriate, and document the injury and investigation as a part of the	20625		

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20625	Continued from page 4 resident's medical record. See also F684 F74: R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in range of motion to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. Additionally, R74 took an anticoagulant (blood thinner), and did not use a bed rail. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, and long-term use of anticoagulants. R74's care plan dated 4/1/25, indicated R74 had a self-care deficit related to confusion, urinary tract infection, catheter use, and required assist of one with bathing, dressing, and personal hygiene. R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse.	20625		

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20625	Continued from page 5 R74's care sheet dated 6/6/25, indicated R74 was on anticoagulants, but lacked information R74 had a bruise. R74's Physician Orders form indicated the following orders: 3/28/25, weekly skin inspection by licensed nurse every Friday evening shift. Complete the weekly skin inspection in PCC. 6/3/25, Warfarin (a blood thinner) 1.5 milligram (MG) by mouth every Monday, Tuesday, Wednesday, and Friday at HS (hour of sleep) until 6/16/25. 6/5/25, Warfarin 1 mg by mouth every Thursday, Saturday, and Sunday at HS until 6/16/25. 6/8/25, make a progress note post fall for 72 hours. Make sure to include any signs or symptoms of injury and effectiveness of new fall interventions. 6/8/25, monitor for signs and symptoms of injury post fall for 72 hours every shift for three days. R74's orders lacked direction for monitoring or assessing the bruise to R74's inner side of right arm identified in the nursing progress notes on 5/28/25. R74's medication administration record (MAR) and treatment administration record (TAR) for May 2025, indicated R74 had a weekly skin inspection on 5/2/25, 5/9/25, 5/16/25, 5/23/25, and 5/30/25. Further, the MAR/TAR lacked direction to monitor or assess R74's bruise to the inner side of the right arm identified on 5/28/25. R74's MAR/TAR for June 2025, indicated R74 had a weekly skin inspection on 6/6/25. Additionally, the MAR/TAR indicated staff documented 6/8/25, and 6/9/25, they monitored for signs and symptoms of injury post fall. The MAR/TAR lacked documentation R74's bruise to the inner side of the right arm identified on 5/28/25, was monitored or assessed.	20625		

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20625	Continued from page 6 R74's nursing progress notes were reviewed and indicated on 5/28/25 at 5:50 p.m., a nursing assistant reported a bruise on R74's inner side of right arm and the nurse asked about the cause. The progress note indicated R74 responded, "Don't ask me, I don't know when and how it happened." Further, the bruise measured approximately 4.5 inches long by 3.5 inches wide and R74 denied pain and further, staff would continue to monitor. Further, the note lacked information an investigation was completed to determine the cause, or if the physician, or resident representative was notified. R74's nursing progress notes dated 6/7/25, indicated R74 was observed falling and hitting his head on the wall. R74 reported his right knee went out and got caught when turning. Under a heading, "Nursing assessment for s/s [signs and symptoms] or pain and/or injury:" indicated R74 had redness to his posterior scalp, and reported right knee discomfort. The note lacked information regarding R74's bruise to his right inner arm. R74's nursing progress notes dated 6/9/25, indicated R74 had a small abrasion to the right knee. The progress notes lacked information regarding R74's bruise to his right inner arm. R74's nursing progress note dated 6/10/25 at 4:25 a.m., indicated R74 had no new injuries related to a recent fall. R74's Weekly Skin Inspection form dated on 5/25/25, and locked on 5/26/25, documented by registered nurse (RN)-A indicated R74 had redness to the groin area, additionally, R74 had purple discoloration to the right upper arm and had no complaints of pain. The note lacked documentation of the size of the discoloration, where on the upper arm the discoloration was, or how R74 obtained the purple discoloration. R74's Weekly Skin Inspection form dated and locked on 5/30/25, indicated R74's skin was clean, dry, and intact and had a pink area to the groin and powder was applied. The form lacked documentation regarding the purple discoloration to the right upper arm, and lacked documentation regarding the bruise identified on 5/28/25 to the inner side of right arm.	20625		

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20625	Continued from page 7 R74's Weekly Skin Inspection form dated and locked on 6/9/25, indicated R74's groin was slightly pink with no open areas and treatment was in place. Further, the note indicated R74 had a pink area to the top of his head from a fall and was not open. The form lacked documentation regarding the purple discoloration to the right upper arm, and lacked documentation regarding the bruise identified on 5/28/25 to the inner side of right arm. During interview and observation on 6/9/25 at 6:45 p.m., R74 had a very large bruise on his right upper inner arm. The bruise was dark purple and was located on the inner side of his arm from his shoulder and extended down to just above R74's elbow. The bruise was approximately 4 inches wide. R74 stated he didn't know what he did to sustain the bruise and stated he had an inkling of what could have happened. R74 stated the hospital beds have those things, R74 pointed to the hand rails on the bed and stated he had a feeling he got his arm caught in the rail and it finally came out. R74 stated he never woke up and didn't know for sure and added, what else could happen when you are laying in bed. During observation on 6/11/25 at 8:53 a.m., R74 was in his wheelchair and his arms were on the inside of the wheelchair resting in his lap. At 8:57 a.m., R74 propelled himself out of his room and his right and left arms were on the arm rests of the wheelchair from wrist to elbow. Did not observe R74 bumping into anything. During interview on 6/11/25 at 10:02 a.m., nursing assistant (NA)-A stated she cared for R74 today and provided R74 a wash cloth and further stated she assists R74 with dressing adding, she got R74's clothes out of the closet and helped donn R74's shirt and stated R74 could put his arms thru the sleeves. NA-A stated R74 did not refuse cares. NA-A stated she would have to report findings of bruises, scratches, and reddened areas. During interview and observation on 6/11/25 at 4:13 p.m., RN-A stated staff used care plans to know what cares a resident required and nurses communicate changes. RN-A further stated refusals were documented in a progress note and in the MAR/TAR if the refusal	20625		

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20625	Continued from page 8 was a treatment or medication and nursing assistants update the nurses. RN-A stated when a resident falls, they check the resident for injuries and complete skin assessments the next few days and monitor a resident for 72 hours after a fall. RN-A stated she thought R74 fell on his right side. RN-A stated if a resident did not know how a bruise occurred, would pass the information on to a supervisor to conduct an investigation. RN-A stated bruises that were light green or yellow were older, and bruises that were red or purple were newer and further stated bruises were monitored weekly on a skin assessment and were added as a treatment in order to monitor them. RN-A viewed R74's record and verified R74's Weekly Skin Inspection form dated 6/9/25, did not mention R74's bruise to the arm. RN-A viewed the skin assessment form dated 5/25/25, that indicated R74 had a purple discoloration to his right upper arm. RN-A further viewed R74's progress note dated 5/28/25, that indicated R74 had a bruise to the inner side of the right arm that measured 4.5 inches long by 3.5 inches wide and further R74 did not know what happened. RN-A stated she documented R74 had purple discoloration but did not measure the discoloration and did not report it to another person. RN-A stated R74 told her the other night he may have reached between his rail. RN-A viewed R74's arm and stated the bruise was fading and was a purple blue in color to the inside of R74's arm. During interview on 6/11/25 at 4:59 p.m., LPN-A stated she expected staff document the bruise. LPN-A goes over progress notes in the a.m., and if she finds a progress note of the skin they try to figure out where it came from. LPN-A further stated if staff find a bruise and it is not documented on admit and staff do not know, it needs to be documented or they need to tell someone. LPN-A further stated she or others will complete an investigation and findings should be in a progress note and further stated monitoring should be on the TAR. LPN-A stated she was not aware R74 had a bruise and asked where the bruise was located and stated she would have to check. LPN-A verified R74 had a progress note dated 5/28/25, that indicated R74 had a bruise and resident did not know what happened. LPN-A viewed R74's orders and verified there were no orders for monitoring R74's bruise. LPN-A viewed R74's incidents and verified there was no investigation conducted. LPN-A stated she did not know how she missed that one. LPN-A stated R74 could remember some things and was better when his wife was at the facility. LPN-A verified R74 had a bruise on his right inner arm and R74 stated the only thing he could figure out was that his arm was in one of those brackets and pointed to the bed rail and LPN-A asked	20625		

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20625	Continued from page 9 R74 if she could measure the bruise. During interview on 6/11/25 at 5:25 p.m., LPN-A later stated she went back through the morning stand up meeting note on 5/28/25, and stated the investigation was completed and R74's bruise was likely due to hitting his arm on the wheelchair and R74 repositioned self a lot with his arms and stated R74 should have had monitoring in place. A copy of the interdisciplinary team (IDT) note was requested. A progress note was later added by LPN-A on 6/11/25 at 6:01 p.m., that indicated R74's bruising was reviewed in IDT on 5/28 and was determined through investigation and observation R47 was leaning over to get something off the floor and bruising was from the wheelchair arm. Further the bruising was purple, diffused with faded edges and measured 24 by 7 and monitoring orders were placed. The note further indicated R74 felt safe and no one harmed him. Additionally, the note indicated the provider was updated on the increased size of the bruise who provided a telephone order for daily measurements, ultrasound, and a new INR (International Normalized Ratio, a lab that measures how long it takes for blood to clot). During interview on 6/12/25 at 8:49 a.m., with the administrator and LPN-A, LPN-A stated R74's bruise measured 24 centimeters (CM) by 7 cm (approximately 9.4 inches by 2.7 inches) and further stated they updated the physician the bruise increased in size and an INR and ultrasound was ordered. The IDT report was again requested and the administrator stated she would pull that information. The administrator stated if an injury was identified, the director of nursing and administrator are notified at standup or if out side that period are notified of a bruise by the nurse or nurse manager and investigate by asking the resident if they know if anyone hurt them, whether they feel safe, observe transfers, mobility and if bumping into edges and stated R74 leans over and grabs things. Once a bruise is identified the family, provider, are notified and monitoring orders are placed and the provider may provide additional orders and would have expected the bruise to be monitored in the medical record. Both the administrator and LPN-A agreed it should have been in the medical record for staff to be able to further assess. An email sent by the administrator on 6/12/25 at 9:23	20625		

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20625	Continued from page 10 a.m., contained a PDF document titled, "5.28 stand up skin". The form indicated, "Wound-Skin Concerns" at the top and was highlighted in yellow. The form contained a section for names, skin concerns, and progress. R74's skin concern indicated R74 had a bruise to the right upper extremity that was new from hitting the wheelchair. An additional PDF document titled, "5.28 24-hour" was also provided that indicated R74 had a bruise on the inner side of the right arm that included measurements 4.5 by 2.5 from hitting on wheelchair per investigation and observation. During interview on 6/12/25 at 9:26 a.m., family member (FM)-A stated she wasn't sure how R74 got the bruise and wondered if R74 got stuck on the thing inside of the bed or if R74 leaned over the side of the wheelchair and thought it was either due to the side rail of the bed or leaning over. FM-A stated she had received more than a call on the bruise and stated the facility tried to figure out how it happened, but didn't think it was on 6/11/25. A policy, Abstract of Medical Records, revised December 2006, indicated survey tag numbers F583, and F842. The policy indicated specific data concerning a resident's medical condition may be released when the resident is transferred to a hospital or other health-related institution and an abstract of the resident's medical record may be made when the resident is transferred to a hospital or other health-related facility. The policy lacked information regarding the facility ensuring the medical record was maintained on each resident that was complete; accurately documented; and readily accessible. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could review/revise policies and procedures for maintaining complete and accurate medical records. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure resident medical records are complete and accurate. The administrator, DON, or designee could then take that information to their quality assessment and performance improvement (QAPI) committee to assess the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty one (21) days	20625		
20875	Adequate and Proper Nursing Care; Monitor TPR	20875	Corrected	07/17/2025

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20875	Continued from page 11 CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure ace wraps were applied for 1 of 1 resident, (R24) reviewed for edema, failed to ensure bruises were assessed and monitored for 2 of 2 residents (R74, R9). Additionally, the facility failed to ensure non-pressure wounds had timely assessments and documentation and provider treatment orders were followed for 1 of 1 resident (R192) who had venous wounds. Furthermore, the facility failed to ensure a referral appointment to a specialty provider was obtained for 1 of 2 residents (R78) reviewed for urinary catheters. Findings include: R24 R24's state optional assessment (OSA) dated 5/26/25, indicated intact cognition, did not reject care, required limited assistance with bed mobility, transfers, and toilet use. R24's quarterly Minimum Data Set (MDS) dated 5/26/25, indicated R24 required partial to moderate assistance with lower body dressing and putting on or taking off footwear, did not have physical, verbal, or other behaviors, and did not reject care. Further, R24 did not have disorganized thinking, an altered level of consciousness or inattention. R24's Medical Diagnosis form indicated the following diagnoses: acute on chronic combined systolic and diastolic congestive heart failure (a condition affecting the heart's ability to pump blood), muscle weakness, adjustment disorder with mixed anxiety and depressed mood, alcoholic cirrhosis of the liver with	20875		

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20875	Continued from page 12 ascites (fluid build up in the space between the lining of the abdomen and abdominal organs), fluid overload, and generalized edema (an accumulation of fluid in the interstitial spaces throughout the body leading to swelling). R24's physician's orders indicated the following order: 7/19/24, monitor, document, and report to physician as needed any signs or symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. 4/24/25, torsemide (a diuretic) oral tablet give 40 milligrams (mg) by mouth two times a day related to cirrhosis of the liver. 4/24/25, spironolactone oral tablet give 150 mg by mouth one time a day for diastolic heart failure related to generalized edema. 5/3/25, "Complete daily edema checks to BLE. [bilateral lower extremities] apply ACE wraps PRN [as needed] if patient requests or edema is noted every day shift for". R24's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated the following order dated 5/3/25, "complete daily edema checks to BLE. Apply ACE wraps PRN If patient requests or edema is noted. every day shift for". The MAR/TAR had a check box indicating the treatment was administered every day from 6/1/25, to 6/11/25. R24's care plan dated 9/24/24, indicated R24 had congestive heart failure and interventions included to monitor, document, and report to the physician as needed any signs or symptoms of congestive heart failure including dependent edema of the legs and feet.	20875		

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20875	Continued from page 13 R24's care plan dated 2/17/25, indicated R24 had an alteration in skin integrity due to localized edema, lymphedema to BLE's, ascites to abdomen and an intervention revised on 7/31/24 indicated R24 had Velcro wraps to BLE's managed by the therapy department however R24's mobility care plan indicated the Velcro wraps were resolved on 1/6/25. R24's nursing progress notes dated 6/6/25 at 5:57 a.m., indicated R24 had edema in the right lower extremity. R24's nursing progress notes dated 6/7/25 at 3:46 p.m., indicated R24 had edema present to the right lower extremity. R24's nursing progress notes with MAR were reviewed 6/6/25 to 6/12/25, and lacked information R24 refused ACE wraps. R24's Daily Skilled Note form dated 6/11/25 at 11:16 a.m., in progress indicated R24 had edema to the right lower extremity. The form contained five check boxed options for cardiovascular interventions that included: elevated affected extremity, compression stockings applied as ordered, encouraged resident to change position slowly, administered cardiovascular medications as ordered, and physician notified of cardiac complications. Documentation on the form indicated R24's extremity was elevated and was encouraged to change positions slowly. The note further indicated R24's edema was improved. During interview and observation on 6/9/25 at 7:12 p.m., R24 had edema to lower extremities and R24 stated he had all his toes amputated on the left foot. R24 had gripper socks on, and his legs were dependent. R24 stated he could get his legs wrapped but stated the nurses never have any time. R24's MAR and TAR indicated his treatment order for monitoring for edema and applying ACE wraps as patient requests or if edema is noted was documented as administered. During interview and observation on 6/11/25 at 2:32 p.m., R24 stated he wanted his legs wrapped but did not get legs wrapped and stated he mentioned he wanted his legs wrapped to the nurse, but the nurse didn't wrap his legs. Reviewed the MAR/TAR that indicated monitoring for edema and applying ACE wraps as patient	20875		

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20875	Continued from page 14 requests or if edema is noted was documented as administered. R24 stated he was supposed to take diuretics but then has to urinate. R24 had edema to mid-calf region of legs and wanted his legs wrapped to keep the swelling down. During interview on 6/11/25 between 2:54 p.m., and 3:00 p.m., registered nurse (RN)-A stated staff knew what cares a resident required thru the care plan and staff documented in a progress note or a note from the MAR and TAR if a resident refused. RN-A stated R24 was alert and a reliable historian who required assistance with dressing. RN-A stated R24 had not had edema and had not seen edema around R24's legs. RN-A further stated when a treatment was completed, it was documented in the TAR. At 3:00 p.m., RN-A viewed R24's legs and stated they looked swollen and verified R24 did not have ACE wraps on. RN-A viewed R24's order and stated the order should have been two orders, to check for edema and apply ACE wraps if resident requested or if edema was noted and stated it needed clarification and she could edit that. During interview on 6/12/25 at 1:10 p.m., nurse care coordinator licensed practical nurse (LPN)-A stated she expected staff apply ACE wraps if there was an order and a resident requested them. LPN-A stated if an order was scheduled and a resident refused, the refusal should be documented and stated R24 did not like to take his full diuretic because he didn't want to void and had significant abdominal edema in the past. LPN-A further stated R24 was alert and oriented and lets staff know what he wants. LPN-A stated it had been a few days since she saw R24's legs. LPN-A verified R24's MAR/TAR had a check mark under R24's order to check for edema and apply ACE wraps if resident requested or if edema was noted and verified R24's skin form dated 6/11/25, indicated R24 had edema and stated they needed to clarify the order and would make sure it was clearer and planned to follow up with nurses to follow the order. R74 R74's significant change MDS dated 5/5/25, indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral	20875		

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20875	Continued from page 15 symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in range of motion to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. Additionally, R74 took an anticoagulant (blood thinner), and did not use a bed rail. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, and long term use of anticoagulants. R74's care plan dated 4/1/25, indicated R74 had a self care deficit related to confusion, urinary tract infection, catheter use, and required assist of one with bathing, dressing, and personal hygiene. R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care sheet dated 6/6/25, indicated R74 was on anticoagulants, but lacked information R74 had a bruise. R74's Physician Orders form indicated the following orders: 3/28/25, weekly skin inspection by licensed nurse every Friday evening shift. Complete the weekly skin inspection in PCC. 6/3/25, Warfarin (a blood thinner) 1.5 milligram (MG)	20875		

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20875	Continued from page 16 by mouth every Monday, Tuesday, Wednesday, and Friday at HS (hour of sleep) until 6/16/25. 6/5/25, Warfarin 1 mg by mouth every Thursday, Saturday, and Sunday at HS until 6/16/25. 6/8/25, make a progress note post fall for 72 hours. Make sure to include any signs or symptoms of injury and effectiveness of new fall interventions. 6/8/25, monitor for signs and symptoms of injury post fall for 72 hours every shift for three days. R74's orders lacked direction for monitoring or assessing the bruise to R74's inner side of right arm identified in the nursing progress notes on 5/28/25. R74's medication administration record (MAR) and treatment administration record (TAR) for May 2025, indicated R74 had a weekly skin inspection on 5/2/25, 5/9/25, 5/16/25, 5/23/25, and 5/30/25. Further, the MAR/TAR lacked direction to monitor or assess R74's bruise to the inner side of the right arm identified on 5/28/25. R74's MAR/TAR for June 2025, indicated R74 had a weekly skin inspection on 6/6/25. Additionally, the MAR/TAR indicated staff documented 6/8/25, and 6/9/25, they monitored for signs and symptoms of injury post fall. The MAR/TAR lacked documentation R74's bruise to the inner side of the right arm identified on 5/28/25, was monitored or assessed. R74's nursing progress notes were reviewed and indicated on 5/28/25 at 5:50 p.m., a nursing assistant reported a bruise on R74's inner side of right arm and the nurse asked about the cause. The progress note indicated R74 responded, "Don't ask me, I don't know when and how it happened." Further, the bruise measured approximately 4.5 inches long by 3.5 inches wide and R74 denied pain and further, staff would continue to monitor. R74's nursing progress notes dated 6/7/25, indicated R74 was observed falling and hitting his head on the wall. R74 reported his right knee went out and got	20875		

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20875	Continued from page 17 caught when turning. Under a heading, "Nursing assessment for s/s [signs and symptoms] or pain and/or injury:" indicated R74 had redness to his posterior scalp, and reported right knee discomfort. The note lacked information regarding R74's bruise to his right inner arm. R74's nursing progress notes dated 6/9/25, indicated R74 had a small abrasion to the right knee. The progress notes lacked information regarding R74's bruise to his right inner arm. R74's nursing progress note dated 6/10/25 at 4:25 a.m., indicated R74 had no new injuries related to a recent fall. R74's Weekly Skin Inspection form dated and locked on 5/2/25, indicated R74 had no new skin issues noted. R74's Weekly Skin Inspection form dated 5/12/25, and locked on 5/14/25, indicated R74's skin was clean, dry, and intact. R74's Weekly Skin Inspection form dated and locked on 5/16/25, indicated R74's skin was clean, dry, and intact. R74's Weekly Skin Inspection form dated on 5/25/25, and locked on 5/26/25, documented by registered nurse (RN)-A indicated R74 had redness to the groin area, additionally, R74 had purple discoloration to the right upper arm and had no complaints of pain. The note lacked documentation of the size of the discoloration, where on the upper arm the discoloration was, or how R74 obtained the purple discoloration. R74's Weekly Skin Inspection form dated and locked on 5/30/25, indicated R74's skin was clean, dry, and intact and had a pink area to the groin and powder was applied. R74's Weekly Skin Inspection form dated and locked on 6/9/25, indicated R74's groin was slightly pink with no open areas and treatment was in place. Further, the note indicated R74 had a pink area to the top of his head from a fall and was not open.	20875		

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20875	Continued from page 18 During interview and observation on 6/9/25 at 6:45 p.m., R74 had a very large bruise on his right upper inner arm. The bruise was dark purple and was located on the inner side of his arm from his shoulder and extended down to just above R74's elbow. The bruise was approximately 4 inches wide. R74 stated he didn't know what he did to sustain the bruise and stated he had an inkling of what could have happened. R74 stated the hospital beds have those things, R74 pointed to the hand rails on the bed and stated he had a feeling he got his arm caught in the rail and it finally came out. R74 stated he never woke up and didn't know for sure and added, what else could happen when you are laying in bed. During observation on 6/11/25 at 8:53 a.m., R74 was in his wheelchair and his arms were on the inside of the wheelchair resting in his lap. At 8:57 a.m., R74 propelled himself out of his room and his right and left arms were on the arm rests of the wheelchair from wrist to elbow. Did not observe R74 bumping into anything. During interview on 6/11/25 at 10:02 a.m., nursing assistant (NA)-A stated she cared for R74 today and provided R74 a wash cloth and further stated she assists R74 with dressing adding, she got R74's clothes out of the closet and helped donn R74's shirt and stated R74 could put his arms thru the sleeves. NA-A stated R74 did not refuse cares. NA-A stated she would have to report findings of bruises, scratches, and reddened areas. During interview and observation on 6/11/25 at 4:13 p.m., RN-A stated staff used care plans to know what cares a resident required and nurses communicate changes. RN-A further stated refusals were documented in a progress note and in the MAR/TAR if the refusal was a treatment or medication and nursing assistants update the nurses. RN-A stated when a resident falls, they check the resident for injuries and complete skin assessments the next few days and monitor a resident for 72 hours after a fall. RN-A stated she thought R74 fell on his right side. RN-A stated if a resident did not know how a bruise occurred, would pass the information on to a supervisor to conduct an investigation. RN-A stated bruises that were light green or yellow were older, and bruises that were red or purple were newer and further stated bruises were	20875		

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20875	Continued from page 19 monitored weekly on a skin assessment and were added as a treatment in order to monitor them. RN-A viewed R74's record and verified R74's Weekly Skin Inspection form dated 6/9/25, did not mention R74's bruise to the arm. RN-A viewed the skin assessment form dated 5/25/25, that indicated R74 had a purple discoloration to his right upper arm. RN-A further viewed R74's progress note dated 5/28/25, that indicated R74 had a bruise to the inner side of the right arm that measured 4.5 inches long by 3.5 inches wide and further R74 did not know what happened. RN-A stated she documented R74 had purple discoloration but did not measure the discoloration and did not report it to another person. RN-A stated R74 told her the other night he may have reached between his rail. RN-A viewed R74's arm and stated the bruise was fading and was a purple blue in color to the inside of R74's arm. During interview on 6/11/25 at 4:59 p.m., LPN-A stated she expected staff document the bruise. LPN-A goes over progress notes in the a.m., and if she finds a progress note of the skin they try to figure out where it came from. LPN-A further stated if staff find a bruise and it is not documented on admit and staff do not know, it needs to be documented or they need to tell someone. LPN-A further stated she or others will complete an investigation and findings should be in a progress note and further stated monitoring should be on the TAR. LPN-A stated she was not aware R74 had a bruise and asked where the bruise was located and stated she would have to check. LPN-A verified R74 had a progress note dated 5/28/25, that indicated R74 had a bruise and resident did not know what happened. LPN-A viewed R74's orders and verified there were no orders for monitoring R74's bruise. LPN-A viewed R74's incidents and verified there was no investigation conducted. LPN-A stated she did not know how she missed that one. LPN-A stated R74 could remember some things and was better when his wife was at the facility. LPN-A verified R74 had a bruise on his right inner arm and R74 stated the only thing he could figure out was that his arm was in one of those brackets and pointed to the bed rail and LPN-A asked R74 if she could measure the bruise. During interview on 6/11/25 at 5:25 p.m., LPN-A later stated she went back through the morning stand up meeting note on 5/28/25, and stated the investigation was completed and R74's bruise was likely due to hitting his arm on on the wheelchair and R74 repositioned self a lot with his arms and stated R74 should have had monitoring in place. A copy of the interdisciplinary team (IDT) note was requested.	20875		

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20875	Continued from page 20 A progress note was later added by LPN-A on 6/11/25 at 6:01 p.m., that indicated R74's bruising was reviewed in IDT on 5/28 and was determined through investigation and observation R47 was leaning over to get something off the floor and bruising was from the wheelchair arm. Further the bruising was purple, diffused with faded edges and measured 24 by 7 and monitoring orders were placed. The note further indicated R74 felt safe and no one harmed him. Additionally, the note indicated the provider was updated on the increased size of the bruise who provided a telephone order for daily measurements, ultrasound, and a new INR (International Normalized Ratio, a lab that measures how long it takes for blood to clot). During interview on 6/12/25 at 8:49 a.m., with the administrator and LPN-A, LPN-A stated R74's bruise measured 24 centimeters (CM) by 7 cm (approximately 9.4 inches by 2.7 inches) and further stated they updated the physician the bruise increased in size and an INR and ultrasound was ordered. The IDT report was again requested and the administrator stated she would pull that information. The administrator stated if an injury was identified, the director of nursing and administrator are notified at standup or if out side that period are notified of a bruise by the nurse or nurse manager and investigate by asking the resident if they know if anyone hurt them, whether they feel safe, observe transfers, mobility and if bumping into edges and stated R74 leans over and grabs things. Once a bruise is identified the family, provider, are notified and monitoring orders are placed and the provider may provide additional orders and would have expected the bruise to be monitored in the medical record. An email sent by the administrator on 6/12/25 at 9:23 a.m., contained a PDF document titled, "5.28 stand up skin". The form indicated, "Wound-Skin Concerns" at the top and was highlighted in yellow. The form contained a section for names, skin concerns, and progress. R74's skin concern indicated R74 had a bruise to the right upper extremity that was new from hitting the wheelchair. An additional PDF document titled, "5.28 24-hour" was also provided that indicated R74 had a bruise on the inner side of the right arm that included measurements 4.5 by 2.5 from hitting on wheelchair per investigation and observation. During interview on 6/12/25 at 9:26 a.m., family member	20875		

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20875	Continued from page 21 (FM)-A stated she wasn't sure how R74 got the bruise and wondered if R74 got stuck on the thing inside of the bed or if R74 leaned over the side of the wheelchair and thought it was either due to the side rail of the bed or leaning over. FM-A stated she had received more than a call on the bruise and stated the facility tried to figure out how it happened, but didn't think it was on 6/11/25. R9 R9's admission Minimum Data Set (MDS) dated 3/14/25, indicated intact cognition and diagnoses of heart failure, spinal stenosis, chronic pain, and long-term use of anticoagulants. If further indicated R9 required staff assistance with most activities of daily living (ADL) and mobility, and received an anticoagulant on a routine basis. R9's physician's orders dated 3/8/25, indicated bilateral tubigrip to both arms (from wrist to elbow areas), on in morning (a.m.) and off at hour of sleep (HS), two times a day. R9's physician's orders further indicated to monitor bruising until resolved, once resolved discontinue order and write a progress note, every shift. R9's order to monitor for bruising lacked a location or description of the bruising. R9's care plan dated 3/14/25, indicated potential for alteration in blood formation and coagulation, related to the use of anticoagulant medication. It further indicated the following interventions: -anticoagulant Medication as ordered by the medical doctor (MD) or physician's assistant (PA) -monitor labs (ie. Protime) as ordered. -monitor and notify MD of signs and symptoms of bleeding. -encourage resident to avoid bumping self. Use soft toothbrush. -monitor for discolored urine, black tarry stools,	20875		

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20875	Continued from page 22 sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, bruising, lethargy, sudden changes in mental status and/or vital signs, shortenss of breath (SOB), and nose bleeds. During observation on 6/10/25 at 9:33 a.m., R9 was not wearing her bilateral Tubi-grips and had a large heart shaped bruise on her left wrist/forearm. During observation on 6/11/25 at 9:38 a.m., R9 was laying in bed, was not wearing her bilateral Tubi grips, and had a large heart shaped bruise on her left wrist. During observation on 6/11/25 at 1:30 p.m., R9 was laying in bed, wasn't wearing her bilateral Tubi-grips, and had a large heart shaped bruise on her left wrist. During interview on 6/11/25 9:54 a.m. licensed practical nurse (LPN)-B stated when a resident had a bruise, it should be documented in the progress notes and put in the orders to monitor it until it was resolved. The orders to monitor should be specific to the bruise and provide a location and description. LPN-B further stated the bruise may also be documented on the skin assessment. During interview on 6/11/25 at 1:38 p.m., NA-A stated NA's were responsible for applying the residents Tubi-grips and verified R9 wasn't wearing hers and should have been. NA-A further stated R9 sometimes refused to put them on but she had not offered/attempted to put them on her today. If R9 refused the Tubi-grips (or other cares) it should be documented. During interview on 6/11/25 at 1:55 p.m. licensed practical nurse (LPN)-C stated when a resident was noted to have a bruise, it should be measured and investigated (to determine the cause), and orders should be put in for monitoring. LPN-C further stated the orders should be specific to the location of the bruise and include a description of it. The bruise should be monitored until it was resolved. LPN-C also stated NA's and nurses were responsible for applying resident Tubi-grips and if the NA applies them, the nurse was responsible for ensuring they were on and then documenting it. Refusals should also be	20875		

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20875	Continued from page 23 documented. During observation on 6/12/25 at 12:10 p.m., NA-B verified R9 had a large heart shaped bruise on her left wrist. NA-B stated NA's were responsible for reporting bruises to the nurse. R9's Weekly Skin Inspections for the month's of May and June of 2025 lacked documentation of a large heart shaped bruise on R9's left wrist/forearm. R9's Skin and Wound Evaluations for the months of May and June 2025 lacked documentation of a large heart shaped bruise on R9's left wrist/forearm. R9's progress notes for 6/1/25-6/12/25 lacked documentation of R9 having a large heart shaped bruise on her left wrist/forearm. R192 R192's admission Minimum Data Set (MDS) dated 6/2/25, indicated R192 was cognitively impaired and had diagnoses of peripheral vascular disease (PVD) and non-pressure chronic ulcers of the feet. R192 had 5 venous ulcers that required dressing changes. R192's provider order dated 6/6/25, indicated R192 required wound care to bilateral lower extremities that included cleanse wounds, pat dry, apply Aquacel AG or calcium alginate AG, gauze, kerlix and ACE wrap every other day and as needed. R192's skin Care Area Assessment (CAA) dated 6/2/25, indicated R192 had PVD and multiple lower extremity wounds with infection. Wound nurse to follow in-house. R192's skin and wound evaluations dated 5/30/25, were started however were still in progress, however all wound assessments had not been completed with description of the wound bed, exudate, pain, infection, and treatment. R192's skin and wound evaluations dated 6/6/25, were	20875		

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20875	Continued from page 24 started however were still in progress. The assessment had not been completed with completed with description of the wound bed, exudate, pain, infection, and treatment. R192's weekly skin assessment dated 6/6/25, indicated R192 had wounds, but lacked assessments of the wounds. R192's care plan dated 6/2/25, indicated R192 had chronic wounds and wound infection to bilateral lower extremities. Interventions included treatment to open areas per order and weekly measurements and assessments. An observation on 6/10/25 at 1:37 p.m., licensed practical nurse (LPN)-F brought R192 into their room to perform dressing changes. R192's socks were removed and both feet had kerlix wrapped on them, however they did not have ace wrap as ordered. LPN-F completed the dressing change per order with the exception of wrapping R192's feet with ace wrap. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could create policies or review and/or revise existing policies and procedures for wound/skin/edema monitoring/documentation. The DON or designee could educate or re-educate nursing staff to those policies and procedures and conduct measurable audits The DON or designee could bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20875		
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives	20895	Corrected	07/17/2025

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20895	Continued from page 25 appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure range of motion (ROM) exercises were completed for 1 of 2 residents (R12) reviewed for ROM. Findings include: R12's annual Minimum Data Set (MDS) dated 3/10/25, indicated R12 was cognitively intact and had diagnoses of quadriplegia (paralysis that impacts all 4 extremities) R12 required substantial to complete assistance with mobility. R12's physical therapy nursing communication form dated 6/26/24, directed staff to complete ROM exercises and stretching exercises daily. The program was posted in R12's room. R12's interdisciplinary department team (IDT) care conference form dated 3/10/25, indicated R12 wanted staff to complete ROM exercises. R12's care plan revised 4/2/25, indicated R12 had an alteration in mobility related to weakness, quadriplegia and right foot drop. Interventions lacked a ROM exercise program. During an observation and interview on 6/9/25 at 1:09 p.m., R12 was in their room in bed. R12 stated staff were supposed to be helping with exercises twice a day. R12 stated there used to be a sign on the wall to show staff what exercises were needed and R12 gestured around the room and stated "it's gone". The exercises were started after therapy ended and just wasn't happening anymore. When interviewed on 6/12/25 at 6:59 a.m., nursing assistant (NA)- A stated if a resident required ROM exercises, it would be on the NA care sheet. When the exercises were completed, they would be documented in the computer. NA-A stated residents can refuse and that	20895		

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20895	Continued from page 26 would be documented too. NA-A verified R12 required ROM exercises and it was listed on the task sheet. NA-A wasn't sure what exercises were needed, and thought it was for his legs and the sign in R12's room would tell staff what was needed. NA-A verified the ROM sign was no longer in R12's room and was not sure what happened to it and stated R12 would ask if he wanted it and would let staff know what to do. When interviewed on 6/12/25 at 2:49 p.m., licensed practical nurse (LPN)-A stated residents who had ROM exercises would have that noted on the NA care sheet as well as a sign in their room. The sign would show staff what kind of exercises were recommended and how many should be done. LPN-A stated R12 was particular and wants to move more and then refuses to do so. LPN-A stated there should be a sign in R12's room and NA staff should be documenting when it was completed or refused. LPN-A reviewed the point of care documentation and stated there was not an option for documentation. LPN-A stated they could not verify if R12 had been recently receiving ROM exercises. A facility policy for ROM was requested however was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that:	20930	Corrected	07/17/2025

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20930	Continued from page 27 B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure cares were provided to minimize risk of aspiration (inhalation of saliva or stomach contents) for 1 of 1 residents (R78) reviewed who required continuous tube feeding. Findings include: R78's admission Minimum Data Set (MDS) dated 5/13/25, indicated R78 had severely impaired cognition and diagnoses of stroke with right sided paralysis and dysphagia (inability to effectively swallow). R78 was dependent on staff for toileting cares and required assistance of one for bed repositioning. R78 received nothing by mouth for nutrition and required continuous tube feeding via a gastrostomy (G-tube, tube in the stomach to provide tube feed nutrition). R78's provider order dated 5/9/25, indicated R78 required the head of bed (HOB) elevated at least 30 degrees during feeding and to pause feeding for 30-60 minutes prior to initiating personal cares where the resident will be lying flat. R78's provider order dated 6/8/25, indicated R78 required Vivonex oral liquid nutritional supplement at 70 milliliters per hour every hour via G- tube for continuous feeding. R78's provider note dated 6/5/25, indicated R78 was hospitalized for aspiration pneumonia from 5/30/25-6/2/25. R78's care plan dated 5/14/25, indicated R78 was at risk for aspiration related to the presence of tube feeding. Interventions included to administer tube feeing as ordered, keep HOB elevated at least 45 degrees during and after feeding, and monitor for signs/symptoms of aspiration.	20930		

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20930	Continued from page 28 An observation on 6/11/25 at 7:58 a.m., nursing assistant (NA)-F entered R78's room to offer repositioning and incontinent cares. R78 was lying in bed with the HOB at approximately 35 degrees and had his tube feeding running. R78 was agreeable to cares and at 8:00 a.m., NA-F lowered R78's HOB flat and assisted R78 to roll to the right side. NA-F determined R78 had a soiled brief and proceeded to provide incontinent and catheter cares. R78 was rolled back and forth mainly on to their right side. R78 coughed a few times when on his right side. The cough sounded wet. NA-F completed the cares and at 8:20 a.m., and then raised R78's HOB back to approximately 35 degrees before leaving R78's room. When interviewed on 6/11/25 at 8:23 a.m., NA-F stated any specific cares needed for residents were found on the care sheets. NA-F stated two staff were needed to boost the resident, however, R78 could roll to the right side well so cares could be done with just one person. NA-F stated it was important to make sure R78's HOB was elevated when done with cares as he had continuous tube feed running. NA-F verified R78 had coughed a few times during cares and said that happened sometimes. NA-F was not aware of needing to turn off the tube feeding for cares and verified that was not listed on the care sheet. NA-F further stated if that was needed, the nurses would need to do that. When interviewed on 6/11/25 at 6:11 a.m., licensed practical nurse (LPN)- D verified R78 was on continuous tube feeding and stated he was tolerating the current tube feeding. LPN-D stated it was ok for R78 to lay flat during cares and there was no restriction for this. LPN-D verified the order for the tube feed to be turned off for 30-60 minutes before any cares lying flat and stated they had not noticed that order before and that was an order that typically was not done. LPN-D then stated NA staff had never asked her to pause the feeding for cares and stated she wasn't sure if R78 needed to lay flat during cares. When interviewed on 6/12/25 at 9:05 a.m., registered nurse (RN)-C stated batch orders were placed when residents had tube feeding. RN-C verified R78's order and stated she had not ever seen an order to pause tube feeding before providing cares where the resident was flat. RN-C did not believe that order should have been ordered it was not a typical order. RN-C stated pausing	20930		

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20930	Continued from page 29 the feeding was to help minimize aspiration, but the time seemed to be like a long period. RN-C further stated the health unit coordinators likely clicked through them and put it in accidently. When interviewed on 6/12/25 at 1:24 p.m., the Director of Nurse (DON) expected staff to follow the orders placed for residents on tube feeding. If the orders didn't make sense, the nurse should be questioning the order. DON further stated it was her understanding staff were following the order and would need to continue to follow up with staff. A facility policy titled Enteral Tube Feeding via a continuous pump revised 3/23/23, directed staff to review the residents care plan for any special needs for the resident. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for tube feeding and minimizing aspiration risk. Nursing staff could be educated to minimize risk of aspiration risk . The DON or designee, should audit placement by all nursing staff assigned to residents effected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	20930		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement their antibiotic stewardship program and ensure antibiotic use was tracked, monitored and appropriate for 1 of 1 residents (R28) who was prescribed an antibiotic. Findings include:	21375	Corrected	07/17/2025

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21375	Continued from page 30 R28's significant change Minimum Data Set (MDS) dated 5/17/25, indicated severely impaired cognition, had a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA), and received an antibiotic on a routine basis. R28's physician's orders dated 3/11/25 indicated Doxycycline Monohydrate 100 milligram (mg) capsule. Give 1 capsule by mouth two times a day related to MRSA as the cause of diseases classified elsewhere. No current stop date due to awaiting an appointment to be scheduled per infectious disease (ID). R28's care plan dated 2/14/25, indicated R28 was on contact precautions for MRSA. Infection control precautions per protocol with the following interventions: -sign on resident's door -treatment for current infection per order R28's Medication Administration Record (MAR) for the months of March 2025-June 2025, indicated R28 starting taking Doxycycline on 3/11/25 and was still taking it currently (as of 6/12/25). A facility document titled Infection Log dated 3/2025-6/2025, indicated R28 had an onset of MRSA cellulitis (skin infection) on 3/9/25 and was started on Doxycycline. There was no antibiotic end date listed. The document did not indicate R28 had continued to be prescribed the doxycycline for the months of 4/2025-6/2025. An interview on 6/12/25 at 1:58 p.m., the infection preventionist (IP) stated when there was a potential or known infection for a resident the information was added to the Infection logs. If an antibiotic was ordered that information was also tracked. Tracking included orders to monitor for symptoms, ensuring there was an end date, and ensuring the infection was resolved, IP verified R28's antibiotic was started in 3/2025 and at that time there wasn't an end date listed. IP wasn't sure why R28 was still on the antibiotic and verified it had not been tracked for the	21375		

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21375	Continued from page 31 months of 4/2025-6/2025. IP stated if the order had been changed to prophylaxis or had changed to include an end date, it would have triggered as a new antibiotic order and been noted on the reports. Since the order had not changed at all, there wasn't the prompt to continue tracking it on the infection log. IP stated it should have been included on the logs and that may have prompted follow up to understand if R28 still needed to be on the antibiotic. A facility policy titled Antibiotic Stewardship Program revised 3/13/23, directed staff to ensure all antibiotics included a duration of treatment (start and end date). The IP or designee will review all antibiotic orders for appropriateness of treatment and if not appropriate, notification to the provider. The IP and consulting pharmacist will monitor antibiotic use tracking through a infection/antibiotic tracking form. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain a method for reviewing appropriate antibiotic use. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure transmission-based precautions (TBP) was maintained for 1 of 1 residents (R2) observed during a transfer and for 1 of 1 residents (R192) who was observed for wound care. Furthermore, the facility failed to ensure hand hygiene	21385	Corrected	07/17/2025

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21385	Continued from page 32 was maintained for 2 of 2 residents (R192, R78) observed during cares. Furthermore, the facility failed to ensure their infection surveillance process was implemented when R78 has suspicion of Clostridioides difficile (C. Diff, a highly contagious communicable disease) and tested positive while in the facility. This had the potential to impact all residents who reside in the facility. Findings include: R2 R2's admission Minimum Data Set (MDS) dated 5/16/25, indicated moderately impaired cognition and diagnoses of Methicillin Resistant Staphylococcus Aureus Infection (MRSA), cellulitis of the buttock, pressure ulcer of left buttock, and Extended Spectrum Beta Lactamase (ESBL) resistance. It further indicated R9 had bilateral impairment to the upper extremities (UE), was dependent on staff for mobility, was always incontinent of bowel and bladder, and had a stage III pressure ulcer. During observation on 6/10/25 at 1:42 p.m., R2 was sitting in his room in his wheelchair, he put on his call light and NA-E anwered it, asking him if he wanted to lay down. He responded yes, and NA-E exited the room. At 1:47 p.m., NA-E came back with a package of briefs, entered R2's room and set them down, went out into the hallway, grabbed the EZ stand lift, and went back into the room and shut the door. NA-E did not put on a gown or gloves before entering the room. At 1:50 p.m., NA-E exited the room and put the EZ stand lift back out in the hallway. R2 was laying in bed. During interview on 6/10/25 at 1:53 p.m., NA-E verified the sign on R2's door indicated he was on contact precautions and stated she was told staff should wear a gown and a mask when entering R2's room but she didn't because "he wasn't wet and didn't need to be changed." During interview on 6/10/25 at 2:04 p.m., registered nurse (RN)-B stated staff should be wearing a gown and gloves when they are in direct contact with the resident and/or their body fluids when a resident was on contact precautions. Some examples of these types of cares were assisting a resident to go to bed,	21385		

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21385	Continued from page 33 transferring them, and changing their linens. During interview on 6/11/25 at 9:50 a.m., nursing assistant (NA)-D stated staff should be wearing a gown and gloves upon entering a residents room who was on contact precautions. During interview on 6/11/25 at 9:54 a.m., licensed practical nurse (LPN)-B stated staff should wear a gown and gloves when performing cares for a resident on contact precautions. During interview on 6/12/25 at 3:16 p.m., the Director of Nursing (DON) stated staff should be wearing a gown and gloves when performing cares for a resident who was on contact precautions. If staff aren't wearing the appropriate PPE, there was an increased risk in spreading illnesses throughout the facility (with anyone those staff come into contact with). R192 R192's admission Minimum Data Set (MDS) dated 6/2/25, indicated R192 was cognitively impaired and had diagnoses of peripheral vascular disease (PVD) and non-pressure chronic ulcers of the feet. R192 had 5 venous ulcers that required dressing changes. R192's provider order dated 6/9/25, indicated R192 required staff to follow contact precautions for MRSA infection in their wounds. An observation on 6/10/25 at 1:37 p.m., licensed practical nurse (LPN)-F pushed R192 into his room. On the door of the room was a sign that stated contact precautions. The sign instructed staff to don gown and gloves before entering the room. LPN-F got R192 situated in their room then exited, performed hand hygiene and donned a gown and gloves before re-entering the room. While gowning up, LPN-F stated she didn't understand why R192 could be outside of the room while on contact precautions and it didn't makes sense to them. Once entering the room, LPN-F gathered supplies. R192 remained in their wheelchair told LPN-F he thought he could help and lift their legs. LPN-F cut and removed R192's left leg dressing first. The wounds were cleaned per orders. Calcium algenate dressing was then	21385		

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21385	Continued from page 34 removed from it's wrapper and cut to fit the wounds for the left foot. LPN-F then removed gloves to look through a box of supplies for a measure tape without any gloves on. A tape was not found, so LPN-F removed her gown and performed hand hygiene as they left the room to obtain measure tape. LPN-F entered the room again with a gown on, but no gloves. Placed the tape on the side table and then without hand hygiene, donned gloves. The wound was washed again as ordered and measured. LPN-H removed gloves and without hand hygiene, placed new gloves and placed the calcium alginate into the wound beds, placed gauze over the calcium alginate and then wrapped in kerlix. LPN-H removed gloves and again went in the box of wound care supplies and found tape. The kerlix was taped down. Without hand hygiene, LPN-F new gloves were placed and a clean sock placed on R192's left foot. LPN-F then removed the sock of the right foot and used the scissors to cut the kerlix on the right foot. LPN-F removed gloves and stopped to re-tie gown. Without hand hygiene, new gloves were placed and finished cutting off the kerlix and removed the remaining gauze and dressing. After exposing the wounds, gloves were removed and without hand hygiene, new gloves placed. LPN-F cleansed the wounds per order. Gloves were removed and without hand hygiene, obtained calcium alginate and placed on wounds. Gauze was then placed and R192's leg was wrapped in kerlix. LPN-F finished cleaning up, removed gown and gloves and performed hand hygiene upon exit of 192's room. When interviewed on 6/10/25 at 2:20 p.m., LPN-F verified she should have been performing hand hygiene in between glove exchanges and should have had gloves in place when looking through the wound supplies in the room. LPN-F stated it was a busy shift, and she wanted to work quickly as R192 was holding his legs up for the dressing changes and thought glove changes would be ok in this situation. R78 R78's admission Minimum Data Set (MDS) dated 5/15/25, indicated R78 had severely impaired cognition and diagnoses of stroke with right sided paralysis. R78 required substantial staff assist with bed mobility and was dependent on staff for toileting cares.	21385		

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21385	Continued from page 35 R78's provider orders showed the following: -on 5/23/25, R78 required a stool sample to rule out C.Diff infection. -on 5/26/25, R78 required Vancomycin oral suspension (antibiotic) 50 milligrams (mg)/milliliter (ml) 2.5ml via gastrostomy tube every 6 hours for C.Diff for 10 days. -on 6/4/25, indicated R78 required staff to follow contact precautions-enteric. R78's care plan dated 5/12/25, indicated R78 had a self-care deficit, and staff were to assist with personal hygiene. R78 further required enhanced barrier precautions (EBP) related to a gastrostomy tube (G-tube). A facility document titled Infection Log dated 6/2025, indicated R78 had C. Diff with symptoms of loose stool. There was no onset date listed. The log indicated R78 had completed 4 days of antibiotic therapy until 6/6/25. The log lacked indication of R78 improving with the antibiotic or if symptoms of loose stools remained. when returning from the hospital on 6/onset of MRSA cellulitis (skin infection) on 3/9/25 and was started on Doxycycline. There was no antibiotic end date listed. A facility document titled Infection Log dated 5/2025, did not include R78 as a resident with suspicion of C. Diff, had tested positive for C. Diff, or had been started on antibiotics for C. Diff. An observation on 6/11/25 at 7:58 a.m., NA-F performed hand hygiene, donned a gown and gloves before entering R78's room for cares. On the outside of R78's door was a sign that read Enteric Contact Precautions. The sign instructed staff to gown and glove when entering room and to wash hands upon exit. NA-F greeted the resident who was sleepy and asked to check for incontinence and reposition. NA-F lowered R78's s head of bed and assisted to roll on their right side. R78 had a soiled brief and needed to be cleaned up. NA-F assisted R78 back onto his back and obtained some supplies from R78's bathroom. NA-F unfastened R78 brief from the	21385		

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21385	Continued from page 36 front and completed front perianal cares and catheter care. NA-F then assisted R78 to roll onto their right side and rolled the soiled brief. NA-F then performed perianal cares from the back and then pulled out the rolled soiled brief and placed in a garbage bag. NA-F then removed gloves and without hand hygiene, donned a new pair. Barrier cream was obtained and placed on R78's bottom. NA-F then removed the left hand glove and without hand hygiene placed another one on. A clean brief was then tucked under R78 and NA-F assisted R78 to roll from side to side and secure it. R78 declined to be further repositioned in bed. NA-F raised R78's HOB and straightened the room before removing gown and gloves and washing hands. When interviewed on 6/11/25 at 8:23 a.m., NA-F acknowledged they had not performed hand hygiene in between glove changes and had not instructed to do that in the past. NA-F stated it also would have increased the time to lower the bed and then go to the hand sanitizer, come back and raise the bed to continue cares. When interviewed on 6/10/25 at 3:29 p.m., RN-C expected staff to wear gown and gloves when entering any room on contact isolation. Furthermore, RN-C expected staff to wear gloves when in contact with a resident's items and in between glove changes. When interviewed on 6/12/25 at 1:58 p.m., the infection preventionist (IP) stated when there was a concern for an infection from residents, they were added to the infection log. This information would be brought up from staff to leaders or discussed in morning meetings. Then it is determined if testing or isolation was needed and then added to the infection log. When asked to review R78's C. Diff infection, IP stated he had came back from the hospital with it. IP was not aware R78 was tested prior and started on antibiotics prior to their hospital leave. IP further verified R78's infection was not tracked on the infection log and wasn't sure if R78 was still having any symptoms. When reviewing the infection logs, there was not any follow up for residents listed if their symptoms and/or infection had resolved. IP stated ideally, all that information would be tracked. IP expected staff to adhere to any TBP that were posted and perform hand hygiene between glove exchanges. This was important to help minimize the spread of infections and to help track infections spreading in the facility.	21385		

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21385	Continued from page 37 A facility policy titled Handwashing Policy revised 2/2024, directed staff to wash hands before conducting a procedure that require gloves and after the removal of gloves. A facility policy titled Transmission Based Precautions revised 7/31/23, directed staff to utilize TBP for residents who are known to be or are suspected of being infected with an infectious agent. A facility policy titled Infection Prevention and Control Program revised directed staff to use surveillance tools to recognize the occurrence of infections, the number and frequency to help detect outbreaks. The surveillance will be reviewed monthly for trends or significant problems since the previous review. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		