DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQNI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**

2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/09/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 11/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 01/18/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/28/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245328 November 21, 2017

Mr. Jay Andress, Administrator
The Margaret S. Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

Dear Mr. Andress:

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

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

Effective October 23, 2017 the above facility is recommended for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 21, 2017

Mr. Jay Andress, Administrator
The Margaret S. Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number S5328025

Dear Mr. Andress:

On October 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 21, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 9, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 7, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 21, 2017, effective October 23, 2017 and therefore remedies outlined in our letter to you dated October 6, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 21, 2017

Mr. Jay Andress, Administrator
The Margaret S. Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

Re: Project Number S5328025

Dear Mr. Andress:

On November 9, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 21, 2017, with orders received by you on October 13, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQNI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**

2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/21/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR-SWS 10/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 11/17/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 6, 2017

Mr. Jay Andress, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number S5328025

Dear Mr. Andress:

On September 21, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 31, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 31, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 21, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

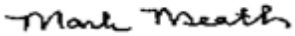
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable temperatures in a range of 71 to 81 degrees Fahrenheit (F) in the hallways and dining room on the transitional care unit (TCU) for 3 of 3 residents (R12, R120, R154). Findings include: R12 admission Minimum Data Set (MDS) dated 9/2/17, indicated R12 was cognitively intact. R120's admission MDS dated 6/29/17, indicated R120 was cognitively intact.	F 257	The facility will ensure comfortable ambient temperatures in the range of 71 to 81 degrees Fahrenheit in the dining room and hallways on the transitional care unit for residents 12, 120 and 154 and for all patients and residents in the Transitional Care Unit (TCU.) Facility maintenance will replace all thermostats on the unit with programmable, locking, electronic thermostats that require codes to access and adjust temperatures. Staff will be instructed to contact maintenance staff to request temperature adjustments on the unit. Maintenance staff will ensure that all adjustments are in the range of 71	10/23/17

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

Electronically Signed | 10/12/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 1 R154's admission MDS dated 7/27/17, indicated R154 was cognitively intact. On 9/18/17 at 4:45 p.m. R12 was interviewed, and stated the room and hallways were, "Colder than ice cubes." R12 stated the other side of the facility was warmer than the TCU. On 9/18/17, at 5:51 p.m. R120 was interviewed, and stated the halls and dining room on the TCU were cold. On 9/20/17, from 7:30 a.m. to 8:45 a.m. the TCU dining room and hallway were continually observed. At 7:30 a.m. R154 was observed sitting in a wheelchair in the hallway. R154 stated it was always so cold in the hallway. At 7:45 a.m. R12 was sitting at the dining room table. R12 stated it was so cold in the dining room. At 8:15 a.m. R154 was sitting at the dining room table, and stated, "It is so cold here." R12 replied, "You are not the only one who is cold. That is why I always wear a sweater, but I am still cold." On 9/20/17, at 9:30 a.m. the environmental services director (ESD) verified the temperature of the hallways on the TCU unit by room 203 and by the nurse's desk was 68.5 degrees F. The ESD verified that the temperature of the TCU dining room was 68 degrees F. The ESD indicated the thermostat across from the TCU dining room was set at 70 degrees F, and stated the thermostat should have been set at 72 degrees F. ESD stated any staff could communicate concerns with temperatures via the computer, and then maintenance staff would adjust the temperature in the hallways as needed. ESD stated based on experience with resident requests, he had found the resident's preferred	F 257	to 81 degrees Fahrenheit. Maintenance Director or designee will audit temperatures on the TCU 5 times per week for 6 weeks to ensure temperatures are in the range of 71 to 81 degrees F and will make immediate temperature adjustments if required. The results of the audits will be reported to, and reviewed by, the facility Quality Assurance and Performance Improvement (QAPI) committee where determination will be made for continued audits. The director of maintenance and/or a designee will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 2 the hallways and public areas to be kept at 72 to 74 degrees F. On 9/20/17, at 10:45 a.m. the administrator stated he was not aware of any complaints that the hallways on TCU were cold, but had noticed at times that the TCU unit was cooler than the rest of the building. The administrator stated he would expect the temperature in the hallways to be between 72 to 74 degrees F. On 9/20/17, at 12:51 p.m. certified occupational therapist assistant-A stated the rest of the building was warmer than the TCU. On 9/20/17, at 12:53 p.m. nursing assistant (NA)-A stated the rest of the building was warmer than the TCU. NA-A stated about half of the time the residents would comment that the unit was cold, especially the women, so she would encourage them to bring a sweater A facility policy for maintaining comfortable temperatures was requested, but not provided.	F 257		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure insulin was administrated as ordered to prevent a significant medication	F 333	Facility assures that the medication needs of each resident are met in a timely manner. R(96) had been discharged from	10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 3 error for 1 of 1 resident (R96) reviewed for significant medication errors. Findings include: R96's Admission Record printed 9/22/17, indicated R96 was admitted to the facility on 8/16/17, with diagnoses that included Type 2 Diabetes. R96's Interagency Transfer Form dated 8/16/17, directed staff to monitor R96's blood glucose levels before meals and at bedtime, and to administer metformin (a diabetic medication) 1000 milligrams twice daily with meals. R96's Physician's Telephone Orders dated 8/17/17, at 4:00 p.m. directed staff to administer Novolog insulin, four times a day according to her blood glucose levels. The insulin was to be administered based on the following: If R96's blood sugar was between 0 to 200 milligrams per deciliter (mg/dL) = No coverage; 201 mg/dL to 250 mg/dL = 2 units; 251 mg/dL to 300 mg/dL = 4 units; 301 mg/dL to 350 mg/dL = 6 units; 351 mg/dL to 400 mg/dL = 8 units; 401 mg/dL to 998 mg/dL = 10 units. R96's August 2017, Medication Administration Record (MAR) indicated R96's blood glucose result on 8/17/17, at 4:30 p.m. was 431 mg/dL. The MAR also indicated R96's blood glucose level was 455 mg/dL at 8:00 p.m. R96's Progress Note dated 8/17/17, at 5:06 p.m. indicated Novolog insulin was not available, and the pharmacy stated the Novolog insulin would be delivered that evening.	F 333	facility at the time of survey. Education provided to all nursing staff on the pharmacy requirement: emergency pharmacy service and emergency kits regarding timeliness of receiving medications and replacing medications from the e-kit. In the event medication is delayed beyond the time frame per pharmacy policy, staff are to notify the MD/NP to request order be placed on hold until medication arrives at the facility or the MD/NP decision on what the treatment should be. Upon arrival of medication staff are to administer. A phone conference call was held on 9-28-17 with the Director of Nursing, Administrator and the operations manager of the pharmacy regarding assurance of medications delivered in a timely manner. Audits will be completed on all units weekly x 8 for 2 months to ensure availability of medications in the e-kit. Audits will be reviewed at the next quarterly Quality Assurance Performance Improvement meeting to determine discontinuation of audits. DON and /or designee responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 4 R96's Progress Note dated 8/17/17, at 6:00 p.m. indicated the pharmacy was called again, and they would deliver the insulin that evening. R96's Progress Note dated 8/17/17, at 9:08 p.m. indicated the pharmacy was called again, and the pharmacy stated they would deliver the insulin that night. R96's Progress Note dated 8/17/17, at 11:08 p.m. indicated the pharmacy was called again regarding insulin delivery, and the pharmacy would deliver the insulin that night. The pharmacy Delivery Slip dated 8/18/17, indicated R96's insulin was delivered at 1:29 a.m. R96's August 2017, MAR indicated R96 had received 10 units of Novolg insulin on 8/18/17, at 8:30 a.m. R96 did not receive the Novolog insulin as ordered on 8/17/17, at 8:00 p.m. On 9/20/17, at 7:43 a.m. licensed practical nurse (LPN)-A was interviewed and stated if a medication was not available in the emergency kit, staff would call the pharmacy and order the medication be delivered stat (immediate), within two hours. LPN-A stated if the facility was unable to obtain a medication, they would call the resident's physician and ask if it would be ok to hold the medication until it arrived. LPN-A stated they would document the discussion with the physician. On 9/20/17, at 1:03 p.m. registered nurse (RN)-A verified an order for sliding scale insulin was given 9/17/17, at 4:00 p.m. because R96's blood glucose levels were elevated. RN-A verified R96's blood glucose levels, and verified no insulin was administered until 8/18/17, at 8:30 a.m. RN-A	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 5 stated she would expect the physician be notified the insulin was not available. On 9/20/17, at 1:33 p.m. the director of nurses (DON) stated she would have expected the physician be notified the insulin was not given per order. On 9/20/17, at 3:00 p.m. the facility medical director stated that the prescribing physician should have been notified of the unavailability of the insulin. The medical director stated the prescribing physician would have made a decision on what the follow up treatment should have been. Facility Adverse Consequences and Medication Errors policy revised April 2014, directed a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufactures specifications, or accepted professional standards and principals of the professional(s) providing services. Examples of medication errors include: Omission- when a drug is ordered but not administered.	F 333		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 6, 2017

Mr. Jay Andress, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

Re: State Nursing Home Licensing Orders - Project Number S5328025

Dear Mr. Andress:

The above facility was surveyed on September 18, 2017 through September 21, 2017 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us**.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 9/18/17, through 9/21/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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

Electronically Signed | 10/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 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 which are in violation of the state statute after the statement, "This Rule 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.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For	21545		10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 2 purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21545	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 3	21545		

facility failed to ensure insulin was administrated as ordered to prevent a significant medication error for 1 of 1 resident (R96) reviewed for significant medication errors.

Findings include:

R96's Admission Record printed 9/22/17, indicated R96 was admitted to the facility on 8/16/17, with diagnoses that included Type 2 Diabetes.

R96's Interagency Transfer Form dated 8/16/17, directed staff to monitor R96's blood glucose levels before meals and at bedtime, and to administer metformin (a diabetic medication) 1000 milligrams twice daily with meals.

R96's Physician's Telephone Orders dated 8/17/17, at 4:00 p.m. directed staff to administer Novolog insulin, four times a day according to her blood glucose levels. The insulin was to be administered based on the following: If R96's blood sugar was between 0 to 200 milligrams per deciliter (mg/dL) = No coverage; 201 mg/dL to 250 mg/dL = 2 units; 251 mg/dL to 300 mg/dL = 4 units; 301 mg/dL to 350 mg/dL = 6 units; 351 mg/dL to 400 mg/dL = 8 units; 401 mg/dL to 998 mg/dL = 10 units.

R96's August 2017, Medication Administration Record (MAR) indicated R96's blood glucose result on 8/17/17, at 4:30 p.m. was 431 mg/dL. The MAR also indicated R96's blood glucose level was 455 mg/dL at 8:00 p.m.

R96's Progress Note dated 8/17/17, at 5:06 p.m. indicated Novolog insulin was not available, and the pharmacy stated the Novolog insulin would be delivered that evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 4 R96's Progress Note dated 8/17/17, at 6:00 p.m. indicated the pharmacy was called again, and they would deliver the insulin that evening. R96's Progress Note dated 8/17/17, at 9:08 p.m. indicated the pharmacy was called again, and the pharmacy stated they would deliver the insulin that night. R96's Progress Note dated 8/17/17, at 11:08 p.m. indicated the pharmacy was called again regarding insulin delivery, and the pharmacy would deliver the insulin that night. The pharmacy Delivery Slip dated 8/18/17, indicated R96's insulin was delivered at 1:29 a.m. R96's August 2017, MAR indicated R96 had received 10 units of Novolog insulin on 8/18/17, at 8:30 a.m. R96 did not receive the Novolog insulin as ordered on 8/17/17, at 8:00 p.m. On 9/20/17, at 7:43 a.m. licensed practical nurse (LPN)-A was interviewed and stated if a medication was not available in the emergency kit, staff would call the pharmacy and order the medication be delivered stat (immediate), within two hours. LPN-A stated if the facility was unable to obtain a medication, they would call the resident's physician and ask if it would be ok to hold the medication until it arrived. LPN-A stated they would document the discussion with the physician. On 9/20/17, at 1:03 p.m. registered nurse (RN)-A verified an order for sliding scale insulin was given 9/17/17, at 4:00 p.m. because R96's blood glucose levels were elevated. RN-A verified R96's blood glucose levels, and verified no insulin was administered until 8/18/17, at 8:30 a.m. RN-A	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 5 stated she would expect the physician be notified the insulin was not available. On 9/20/17, at 1:33 p.m. the director of nurses (DON) stated she would have expected the physician be notified the insulin was not given per order. On 9/20/17, at 3:00 p.m. the facility medical director stated that the prescribing physician should have been notified of the unavailability of the insulin. The medical director stated the prescribing physician would have made a decision on what the follow up treatment should have been. Facility Adverse Consequences and Medication Errors policy revised April 2014, directed a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufactures specifications, or accepted professional standards and principals of the professional(s) providing services. Examples of medication errors include: Omission- when a drug is ordered but not administered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or pharmacist or their designee, could develop and implement policies/procedures to assurance that the medication needs of each resident are meet in a timely manner. The DON and/or pharmacist or their designee could educate staff on these policies/procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 6 (21) days.	21545		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable temperatures in a range of 71 to 81 degrees Fahrenheit (F) in the hallways and dining room on the transitional care unit (TCU) for 3 of 3 residents (R12, R120, R154). Findings include: R12 admission Minimum Data Set (MDS) dated 9/2/17, indicated R12 was cognitively intact. R120's admission MDS dated 6/29/17, indicated R120 was cognitively intact.	21705	Corrected	10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21705	Continued From page 7 R154's admission MDS dated 7/27/17, indicated R154 was cognitively intact. On 9/18/17 at 4:45 p.m. R12 was interviewed, and stated the room and hallways were, "Colder than ice cubes." R12 stated the other side of the facility was warmer than the TCU. On 9/18/17, at 5:51 p.m. R120 was interviewed, and stated the halls and dining room on the TCU were cold. On 9/20/17, from 7:30 a.m. to 8:45 a.m. the TCU dining room and hallway were continually observed. At 7:30 a.m. R154 was observed sitting in a wheelchair in the hallway. R154 stated it was always so cold in the hallway. At 7:45 a.m. R12 was sitting at the dining room table. R12 stated it was so cold in the dining room. At 8:15 a.m. R154 was sitting at the dining room table, and stated, "It is so cold here." R12 replied, "You are not the only one who is cold. That is why I always wear a sweater, but I am still cold." On 9/20/17, at 9:30 a.m. the environmental services director (ESD) verified the temperature of the hallways on the TCU unit by room 203 and by the nurse's desk was 68.5 degrees F. The ESD verified that the temperature of the TCU dining room was 68 degrees F. The ESD indicated the thermostat across from the TCU dining room was set at 70 degrees F, and stated the thermostat should have been set at 72 degrees F. ESD stated any staff could communicate concerns with temperatures via the computer, and then maintenance staff would adjust the temperature in the hallways as needed. ESD stated based on experience with resident requests, he had found the resident's preferred	21705		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21705	Continued From page 8 the hallways and public areas to be kept at 72 to 74 degrees F. On 9/20/17, at 10:45 a.m. the administrator stated he was not aware of any complaints that the hallways on TCU were cold, but had noticed at times that the TCU unit was cooler than the rest of the building. The administrator stated he would expect the temperature in the hallways to be between 72 to 74 degrees F. On 9/20/17, at 12:51 p.m. certified occupational therapist assistant-A stated the rest of the building was warmer than the TCU. On 9/20/17, at 12:53 p.m. nursing assistant (NA)-A stated the rest of the building was warmer than the TCU. NA-A stated about half of the time the residents would comment that the unit was cold, especially the women, so she would encourage them to bring a sweater A facility policy for maintaining comfortable temperatures was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop systems to ensure temperatures are maintained at a comfortable levels for residents. The director of maintenance or designee could educate all appropriate staff. The director of maintenance or designee could develop monitoring systems to ensure ongoing compliance. The director of maintenance could report these results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21705		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey The Margaret Parmley Residence 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Margaret Parmley Residence is a 1-story building with a no basement. The building was constructed in 1972, construction 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 detection in spaces open to the corridor, that is monitored for automatic fire department	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 notification. The facility has a licensed capacity of 101 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has	K 324	Semi-annual inspections of the kitchen hood ventilation and fire suppression	10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 3 failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 (11), states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect the residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 11:00 a.m. to 3:00 p.m. on 09/21/2017, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by the Maintenance Supervisor.	K 324	system will be completed timely. At the time the deficiency was noted, the facility took immediate action and scheduled the hood inspection. The inspection was completed on October 3, 2017. The facility maintenance director will monitor and sustain compliance by scheduling all required inspections in the electronic preventative maintenance program (TELS) where it will be tracked and stored. The facility maintenance director will conduct monthly audits x 3 months of all required life safety equipment and systems inspections to ensure compliance. The results of the audits will be reported to, and reviewed by, the facility Quality Assurance and Performance Improvement (QAPI) committee where determination will be made for continued audits. The director of maintenance and/or a designee will be responsible for ongoing compliance.	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 76 of 76 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 09/21/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any documents or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 901	The facility will conduct a complete and current Room Risk Assessment in accordance with NFPA 99 Health Care Facilities Code 2012 edition on or before October 23, 2017. The Risk Assessment will be located and stored in the facility Emergency Preparedness Manual. The risk assessment will be updated/reviewed annually or on an as-needed basis when facility structure or use is changed or modified. The Director of Maintenance and/or a designee will be responsible for ongoing compliance.	
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 5 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 76 of 76 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 09/21/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	The facility will ensure that electrical outlet testing and maintenance in all resident/patient occupied rooms is completed in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition on or before October 23, 2017. The facility maintenance director will monitor and sustain compliance on an ongoing basis by scheduling all required annual electrical outlet inspections in the electronic preventative maintenance program (TELS) where it will be tracked and stored. The director of maintenance and/or a designee will be responsible for overall compliance.	