Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 29, 2024

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

RE: CCN: 245328
Cycle Start Date: September 17, 2024

Dear Administrator:

On October 24, 2024, 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
October 1, 2024

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

RE: CCN: 245328
Cycle Start Date: September 19, 2024

Dear Administrator:

On September 19, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 December 19, 2024 (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 March 19, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	C 09/19/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/16/24 through 9/19/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 9/16/24 through 9/19/24, 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 complaints were reviewed with no deficiencies cited: H53287650C (MN00097152) and H53288200C (MN00105693). 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 attained.	F 000		
F 604	Right to be Free from Physical Restraints	F 604		10/18/24

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

Electronically Signed | 10/04/2024

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

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F 604 SS=D	Continued From page 1 CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure methods to restrain residents were not used for 1 of 1 residents (R74) reviewed for restraints.	F 604	POC F604 Right to be Free from Physical Restraints Pillow was immediately removed from under the fitted sheet for R74. Immediate education provided to staff on the unit for	

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F 604	Continued From page 2 Findings include: R74's admission Minimum Data Set (MDS) dated 8/12/24, indicated R74 was cognitively intact and had diagnoses of lung cancer, repeated falls, and weakness. R74's care plan revised 9/18/24, indicated R74 had alterations in cognition due to brain cancer. Interventions included to provide supervision as needed. Furthermore, R75 had an alteration in mobility related to a history of falls, imbalance, and weakness. Interventions included to assist with movement in and out of bed, concave mattress in place, fall mat, and low bed. R74's provider and nursing orders lacked indication restraints were ordered. R74's fall incident and review analysis dated 8/9/24, indicated R74 had a fall from bed. It was determined R74 was self-positioning in bed when the fall occurred. R74's fall incident and review analysis dated 9/12/24, indicated R74 had a fall from bed. It was determined R74 was reaching for the call light that was attached, but not in reach when the fall occurred. R74's fall incident and review analysis dated 9/17/24 indicated R75 had a fall from bed. It was determined R74 did not put on call light to alert staff prior to getting out of bed when the fall occurred. R74's nursing progress note dated 9/14/24, at 11:20 a.m., indicated R74 was yelling from room. When staff arrived, resident was laying on their	F 604	R74. Audit completed to ensure no other residents currently affected. Residents that have sustained a fall from bed have the potential to be affected.. Education on Resident Bill of Rights will be provided to all nursing and therapy staff who reposition residents in bed outlining the right to be free from any type of restraints. Audits on all residents that have sustained a fall from bed to ensure zero type of restraints being used will be completed weekly x4 then monthly x2. 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 DON/Designee Date of Compliance: 10/18/2024	

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F 604	Continued From page 3 stomach with legs out of bed on windowsill. An observation on 9/16/24 at 2:09 p.m., R74 was lying in bed sleeping on his back. The bed was pushed up close to the wall with a window. R74 had a concave mattress in place. In the middle of the mattress where there was a gap in the raised edges of the mattress was a pillow that had been placed under the fitted sheet. The pillow was not positioned underneath R74, but along side of them. An observation on 9/16/24 at 5:43 p.m., nursing assistant (NA)-E entered R74's room to assist R74 with incontinent cares. NA-E donned gloves and pulled down the resident blanket. A pillow was placed under the fitted sheet of R74's concave bed, where there was a gap in the raised edges of the concave mattress. NA-E removed the pillow from underneath the sheet before assisting with the incontinent cares. Upon completion of the cares NA-E went to the head of the bed to pull the draw sheet and boost R74 up in bed. Then NA-E took a pillow and tucked it under R74's fitted sheet beside him in the gap of the raised edges of the concave bed. NA-E finished settling R74 and exited the room. When interviewed on 9/16/24 at 5:59 p.m., NA-E stated R74 was a high risk for falls and had rolled out of bed before. NA-E stated the pillow was placed under the fitted sheet to prevent R74 from rolling out of bed. NA-E further stated they weren't sure if R74 could remove the pillow as it would be in an awkward position and R74 had some weakness. An observation on 9/19/24 at 7:19 p.m., R74 was in bed laying on his back awake. At the edge of	F 604		

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F 604	Continued From page 4 R74's bed, the fitted sheet was pulled up some and a pillow was underneath the fitted sheet closer to R74's knees and lower legs. An observation on 9/19/24 at 7:39 p.m., NA-A entered R74's room. NA-A assisted R74 with drinking some water and offered R74 to get up for breakfast. R74 declined. NA-A verified the pillow was tucked under the fitted sheet near R74's lower legs and removed it. When interviewed on 9/19/24 at 7:59 a.m., NA-A stated the pillows were not supposed to be under fitted sheets and it was not a practice of theirs. NA-A stated R74 was a fall risk and had falls from their bed. NA-A further stated the pillow was likely placed to prevent R74 from swinging their legs over the side of the bed and used to help keep him in bed. NA-A stated R74 wouldn't have been able to remove it as it was under the fitted sheet. When interviewed on 9/19/24 at 8:05 a.m., licensed practical nurse (LPN)-A stated pillows should not be placed under fitted sheets as it could prevent them from getting out of bed. LPN-A further stated R74 could have placed it there or the significant other may have. LPN-A further stated R74 may be able to remove it as their strength can vary from time to time. When interviewed on 9/19/24 at 1:22 p.m., the Director of Nursing (DON) expected staff not to place pillows under fitted sheets to help keep residents from rolling or getting out of bed. That would not be an appropriate intervention for falls. DON further stated a concave mattress would be used as an intervention when a resident had rolled out of bed. The consulting nurse stated	F 604		

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F 604	Continued From page 5 pillows may be used if the resident was assessed and able to swing their legs or get up with them in, however was unable to provide an assessment showing R74's ability to do so. A facility policy on restraint use was requested however, the facility stated restraints would be followed under the resident rights policy. That policy was not provided.	F 604		
F 684 SS=D	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 and document review, the facility failed to ensure a bowel regimen was initiated for 1 of 1 residents (R18) reviewed for constipation. Findings include: R18's significant change Minimum Data Set (MDS) dated 8/27/24, indicated R18 was cognitively intact and had diagnoses of a right arm fracture, depression, and diabetes. R18 was continent of bowel and bladder and had frequent pain. R18's bowel evaluation dated 8/27/24, indicated	F 684	F684 Quality of Care NP wrote orders for R18 for Senna daily and as needed. Order was entered on 9/19/24. Any resident that is on narcotics have the potential to be affected. Education on documentation of bowl movements and following the bowl protocol, ensuring orders are placed appropriately was provided to all nursing staff. Audits on all residents or new admissions on narcotics to ensure they have a bowl regiment in place will be completed weekly x4 then monthly x2. The results of	10/18/24

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F 684	Continued From page 6 R18 lacked indication R18 had diagnoses or medications that contributed to bowel dysfunction or required any individualized treatment plan. R18's care plan revised 9/10/24, indicated R18 had a potential alteration in elimination due to right wrist and shoulder fracture and weakness and was independent with toileting transferring from the wheelchair. Interventions included to monitor bowel movements (BM) as they occur and administer bowel medications as ordered. R18's follow-up question report for 8/31/24-9/18/24, indicated R18 had four days without a BM between 8/31/24- 9/5/24, and again from 9/13/24-9/18/24. A facility document titled BM list, no date, directed staff to initiate the following: -administer Milk of magnesia (medication to prevent constipation) 30 milliliters (ml) if 3 days from last BM. -administer Dulcolax suppository (medication to prevent constipation) if 4 days from last BM -administer fleets enema (medication to prevent constipation) if 5 days from last BM -administer magnesium citrate (medication to prevent constipation) and update the provider if no BM for 6 days. R18's medical record lacked evidence R18 had been offered or received bowel medications to help with constipation. R18's consultant pharmacist recommendation to physician dated 7/29/24, indicated R18 had requested a stool softener for hard stools and discomfort. R18 received scheduled MS contin (narcotic pain medication) and scheduled hydromorphone (narcotic pain medication) which	F 684	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 DON/Designee Date of Compliance: 10/18/2024	

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F 684	Continued From page 7 can cause constipation. CP recommended initiating a bowel regimen as currently none was on file. The provider responded to the recommendation on 9/16/24 and ordered senna (medication to prevent constipation) 8.6 milligrams (mg) daily and senna 8.6 mg daily as needed for constipation. R18's provider and nursing orders reviewed 9/19/24, lacked indication R18 was started on the bowel regimen. When interviewed on 9/16/24 at 5:27 p.m., R18 stated they have trouble with constipation. R18 stated nursing staff don't ask about constipation or frequency of BM. R18 stated they try to drink prune juice at breakfast to help but doesn't always work. R18 had requested some medication to help but has not received any yet. R18 stated the last BM was a few days ago and stated, "I am miserable". When interviewed on 9/19/24 at 8:49 a.m., nursing assistant (NA)-A stated when a resident has a BM, it was documented. If it had been a few days, the system will have an alert. NA-A stated if the alert was seen, the nurse would be notified. NA-A hadn't worked with R18 in a while and wasn't aware of any discomfort or complaints of constipation. When interviewed on 9/19/24 at 10:06 a.m., licensed practical nurse (LPN)-A stated every night the night team would complete a BM list. The list included residents who had no BM for greater 3 days and listed a standing order of bowel medication to provide. The day shift would then review the list, do an assessment, and give the medications. LPN-A did not have one for the prior night as the agency staff were not always	F 684		

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F 684	Continued From page 8 aware of the process and the lists were not saved. LPN-A stated R18 was a risk for constipation as they were not as mobile with her recent fractures, and she takes scheduled narcotics. LPN-A stated R18 drinks prune juice and usually that worked for her. LPN-A stated when R18 used prune juice it wouldn't necessarily be documented. When interviewed on 9/19/24 at 1:27 p.m., the Director of Nursing (DON) stated the night nurse completed the BM list and the day shift would implement a one-time order for bowel medications. DON verified R18's BM record and noted there were times when standing orders for medications should have been implemented. If R18 had refused the bowel medications, staff were expected to document. A facility policy/procedure for constipation was requested and was informed the standing orders would be followed. Standing orders for constipation, no date, directed staff to -consider rectal check to determine if impaction was present -encourage 2,000 fluid intake unless contraindicated -consult nutrition services for dietary recommendations -give senna 8.6mg two tabs at night as needed for 3 days -bisacodyl suppository 10 mg daily as needed for 3 days -reattempt senna or bisacodyl if no results after 24 hours and notify the provider -monitor for results	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		10/18/24

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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
F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement pressure ulcer interventions for 2 of 3 residents (R25, R68) reviewed for pressure ulcers. Findings include: R25 R25's significant change Minimum Data Set (MDS) dated 7/24/24, indicated severely impaired cognition and diagnoses of blister (non-thermal) on left foot, local infection of the skin and subcutaneous tissue, and cellulitis of left lower limb. It further indicated R25 required substantial to maximal assistance with bed mobility, was dependent on staff for all other mobility, always incontinent of bowel and bladder, and was at risk for pressure injury. R25's Care Area Assessment (CAA) worksheet from MDS dated 7/24/24 triggered pressure	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Prevalon boots were applied to R25 on 9/19/24. Education will be provided to all nursing staff on Policy Skin Assessment and Wound Management, following care sheet/care plan for skin integrity. For R68 education will be provided to all nursing staff on Policy Skin Assessment and Wound Management, following care sheet/care plan for repositioning. All residents that require repositioning and wound management have the potential to be affected. Education provided to all nursing staff on Policy Skin Assessment and Wound Management, following care sheet/care plan for skin integrity, documentation of refusals, and repositioning will be provided. Audits will be completed on residents that require repositioning and wound	

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F 686	Continued From page 10 ulcer/injury and indicated the following: Staff to follow therapy/care plan recommendations for all activities of daily living (ADL) and mobility. Staff to leave call light within reach and bed at working height. Braden score 16 indicating risk for skin breakdown. Patient has wound to finger-staff to treat as ordered with wound care (WOC) nurse to follow in-house. Patient has a pressure redistribution mattress and wheelchair cushion, turn and reposition schedule, monitoring of skin integrity with morning (a.m.) and hour of sleep (HS) cares and weekly skin inspection with bath/shower. Complications can include potential for skin breakdown, infection and pain. Will proceed to care plan, for interventions to minimize the risk of pressure ulcer/injury. R25's physician's orders indicated: -9/16/24 wound care to blister left heel: clean with wound cleanser, pat dry, skin prep to peri wound, apply Santyl, cover with ABD pad; wrap with kerlix, change every day and as needed. -7/26/24 float heels while in bed to relieve pressure off of heels, every shift. -10/13/23 encourage blue boots to be on except with transferring, every shift. R25's nursing assistant's care sheet (undated) indicated, R25 had a blister on her left heel, encourage blue boots to be on at all times except during transfers, and encourage floating heels. R25's care plan dated 5/16/24, indicated alteration in skin integrity related to a urinary tract infection (UTI), weakness, venous stasis dermatitis, lymphedema to bilateral lower extremities (BLE). Left dorsum venous ulcer 2nd toe. It also indicated the following interventions: -encourage blue boots at all time except with	F 686	management weekly x4 then monthly x2 to ensure appropriate repositioning, documentation of refusals, and following care sheet/care plan for skin integrity interventions are being followed. 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 DON/Designee Date of Compliance: 10/18/2024	

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F 686	Continued From page 11 transfers. -lymph therapy. -monitor skin integrity daily during cares. Weekly skin inspection by nurse.-Treatment to open area per order -turn and reposition or reminders to offload every 2-3 hours and as needed. -pressure redistribution mattress to bed -pressurer redistribution cushion to wheelhair, chair -monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor (MD) or physician's assistant (PA). -document on skin condition and keep MD or PA informed of changes -followed by Wound Care. During observation on 9/17/24 at 11:57 a.m., the assistant director of nursing (ADON) verified there was a pillow under the back of R25's lower legs and ankles. The pillow was thin, laying flat on the bed and R25 had bare feet with her heels laying directly on the pillow and not floating. Her left heel/ankle had a dressing. The ADON also verified R25 had one pressure injury to her left heel and was also not wearing blue foam heel protectors/boots. During observation on 9/18/24 at 9:00 a.m., nursing assistant (NA)-A looked at her nursing assistant care sheet and verified R25 was supposed to be wearing heel protectors stating "The care sheet says prevalon boots to both feet except during transfers." The surveyor and NA-A went into R25's room and NA-A was unable to locate her blue foam boots and also verified her feet were not floating. There was a pillow laying flat under both ankles but her heels were laying on the bed. NA-A stated if a resident refused	F 686		

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F 686	Continued From page 12	F 686		

cares they should let the nurse know and document it. NA-A stated they would come back to R25's room later, re-position her, and see if she will let them float her heels on a pillow.

During observation on 9/19/24 at 8:00 a.m., R25 was laying in bed on her back. The blue foam heel protectors/boots were laying in her wheelchair and both of her heels were laying directly on the bed and not floating. Her left ankle/heel was wrapped in a dressing.

R68

R68's quarterly Minimum Data Set (MDS) dated 8/12/24, indicated severe cognitive impairment and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and chronic pain syndrome. It further indicated R25 had an impairment on the left side of her upper and lower extremities, was dependent on staff for most ADL's and mobility, frequently incontinent of bladder and always incontinent of bowel. R25 was at risk for and had (1) unstageable pressure injury (coccyx) present on admission and a wound vacuum assisted closure (VAC).

R68's nursing assistant care sheet (undated), indicated R68 had a wound VAC on her coccyx and shouldn't be in her chair longer than 2-3 hours.

R68's care plan dated 8/12/24, indicated an alteration in skin integrity and risk for further breakdown related to cerebrovascular accident (CVA), altered mental status, dysphagia, obsessive compulsive disorder (OCD), paranoid schizophrenia, hemiplegia and hemiparesis

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F 686	Continued From page 13 affecting left non-dominant side unstageable coccyx pressure ulcer on admission, and wound vac placed 3/5/24. It further indicated the following interventions: -monitor skin integrity daily during cares. Weekly skin inspection by nurse. -treatment to open areas per order -turn and reposition or reminders to offload q 2-3 hours and as needed -pressure redistribution mattress to bed -pressure redistribution cushion to wheelchair, chair -staff to perform pericare after each incontinent episode and as neeed -low air loss air bed, pressure redistribution -heel lift boots. -dietary interventions, including encourage supplements as ordered -weekly measurements and assessment of wound -monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to MD or PA. -document on skin condition and keep MD or PA informed of changes -followed by wound care. -encourage repositioning every 1-2 hours side to side staying off coccyx -up in chair for no longer than 1-2 hours During continuous observation on 9/17/24 at 12:32 p.m., R68 was sitting in her wheel chair in the dining room eating lunch at a raised bedside table. -12:50 p.m. nursing assistant (NA)-D asked R25 if she was finished eating, R25 responded "yes." so NA-D removed her clothing protector and her meal tray. Then LPN-A came in and administered her medication. NA-D brought her out to the common/TV area and put her in front of the TV.	F 686		

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F 686	Continued From page 14 -1:02 p.m. LPN-A took her vital signs. -1:07 p.m. R68 fell asleep in her wheelchair. -1:21 p.m. R68 dozed off/on in her wheelchair. -1:34 p.m. same as above -1:49 p.m. therapeutic recreation (TR) staff (unknown) brought her back to the dining room to play black jack, adjusted her wheelchair to a sitting position to play cards. -1:54 p.m. R68 started yelling/calling out for Tylenol, so TR staff (unknown) brought her back to the nursing station. -2:04 p.m. R68 received Tylenol -2:06 p.m. staff (unknown) brought her back down to the dining area to play black jack. -3:07 p.m. TR brought her back to the common/TV area. -3:12 p.m. R68 fell asleep in her wheelchair. -3:21 p.m. LPN-A and NA-F took her to her room and transferred her using the Hoyer lift from her wheelchair to her bed. Staff failed to offer R68 to re-position or lay down in bed from 12:32 p.m. to 3:21 p.m. during the continuous observation. During interview on 9/17/24 at 3:17 p.m., LPN-A stated R68 had been up in her wheelchair since 11:50 a.m. and was supposed to be repositioned every 2 hours and shouldn't be in her wheelchair more than 2 hours at a time. LPN-A further stated there may be times R68 was in her wheelchair longer then 2 hours if she was participating in an activity. During interview on 9/18/24 at 8:27 p.m., NA-D stated they got R68 up for lunch yesterday (9/17/24) at 11:50 a.m. and she can be in her wheelchair as long as she can tolerate it. NA-D further indicated they should ask the residents if they want to lay down and complete rounds every 2 to 2.5 hours to re-position, check/change their	F 686		

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F 686	Continued From page 15 brief, see if they need anything, etc. During interview on 9/19/24 at 9:54 a.m., licensed practical nurse (LPN)-C stated R25 should wear blue foam heel protectors/boots at all times except during transfers. If she refuses to wear the heel protectors then staff should be floating her heels off the bed which means her heels shoudn't be laying on the mattress. If a resident refuses treatment or care, the NA's should let the nurses know and the nurses should be documenting the refusal. LPN-C verified both R25 and R68 lacked documentation of any refusals of care (specifically regarding pressure ulcer interventions). R68 should not be in her wheelchair for longer 2 hours and staff was responsible for offering and to document if she refused. During interview on 9/19/24 at 11:30 a.m. the director of nursing (DON) should stated nursing staff should be following care planned interventions and verified R68 should only be in her wheelchair for 1-2 hours. The DON also stated when floating a resdent's heel they need to be off of the mattress and not laying directly on it. If a resident refuses cares, staff should reapproach 3 times, try having a different staff reapproach the resident, notify the nurse, and the nurse should document it as well as the NA. The facility's policy on skin assessment and wound management dated 3/2024, indicated guidelines for assessing and managing wounds which included the following: 1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2. Implement appropriate preventative skin	F 686		

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F 686	Continued From page 16 measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. 3. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. 4. Staff will perform routine skin inspections (with daily care). 5. Nurses are to be notified if skin changes are identified. 6. A weekly skin inspection will be completed by licensed staff.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: R69's quarterly Minimum Data Set (MDS) dated 8/20/24 indicated intact cognition and diagnoses of traumatic subarachnoid hemorrhafe with loss of consciousness of 30 minutes or less, adjustment disorder, and nicotene dependence. It further indicated R69 was independent with all activities of daily living (ADL) and mobility and had no history of falls. R69's Smoking Evaluation dated 8/20/24, indicated resident currently Identifies as a	F 689	F689 Free of Accident Hazards/Supervision/Devices Immediate education with R69 was provided. Education included LOA policy and smoking policy. All residents have the potential to be affected. Appropriate cigarette disposal provided alongside street sidewalk. R69 was educated on LOA policy and smoking policy. Front door garbage was removed.	10/18/24

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F 689	Continued From page 17 smoker. Resident was aware of smoking policy to store all smoking materials in the cart, sign out before leaving facility, and to leave facility grounds when smoking. Assessment will continue and updates will be made to nurse practioner (NP)/medical doctor (MD). R69's smoking evaluation lacked documentation that staff had observed him while smoking. R69's care plan dated 8/20/24, indicated R69 identified as smoker. Independent to leave property safely, following LOA policy. It further indidcated the following interventions: -smoking evaluation per facility policy and PRN -smoking materials will be stored safely with nursing staff. During interview on 9/17/24 at 12:59 p.m., R69 stated he had to go "to the street" to smoke and he kept his smoking materials in the seat of his walker during the day but at the end of the day he gave them to the nurse. R69 further stated he disposed of the cigarette butts in the trash can when he came back to the facility. He used to live on the golf course and you weren't allowed to leave trash on the ground. During observation on 9/17/24 at 4:30 p.m., R69 was walking out of the building with his walker. He walked to the side of right side of the building when coming out of the facility and started smoking in the parking lot.	F 689	Audits of all smoking residents will be completed weekly x4 then monthly x2 to ensure they have signed out to smoke, smoked off campus, and disposed cigarettes appropriately. 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 Social Work Director/Designee Date of Compliance: 10/18/2024	

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F 689	Continued From page 18	F 689		

During observation on 9/18/24 at 11:36 a.m., R69 ambulated independently with walker out the front door and into the facility parking lot. R69 sat down on the seat of the walker and lit a cigarette and proceeded to smoke.

During an interview on 9/18/24 at 11:44 a.m., the director of nursing (DON) verified R69 was not in the designated smoking area (off-campus) and reminded R69 regarding the policy to sign out in the leave of absence book and to go off-campus to smoke since the facility is a non-smoking facility.

During observation on 9/18/24 at 11:46 a.m., R69 ambulated to the front door, rolled the cigarette between his two fingers and thumb and threw the cigarette in the trash can which had a clear plastic trashcan liner and several different pieces of paper products in the trash.

During an observation on 9/18/24 at 11:51 a.m., noted inside the top of the trash can was black however, did not note any melted plastic or burns. Noted black/grey ashes on the lip of the trash can at the opening. Also, noted melted plastic in a circular shape by the opening of the trash can.

During review on 9/18/24 at 12:03 p.m., noted R69 had not signed out to go off campus to smoke. The DON verifieed R69 did not sign out.

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F 689	Continued From page 19 During interview on 9/18/24 at 12:18 p.m., licensed practical nurse (LPN)-D stated they didn't know who was responsible for filling out smoking assessments but it was probably the nurse who was admitting the resident. During interview on 9/18/24 at 12:20 p.m. the assistant director of nursing (ADON) stated residents should be asssed for smoking on admission, with any MDS assessments, and as needed. The staff who is compelting the assessment should actually observe the resident smoking to ensure they are safe to do so. During observation on 9/18/24 at 12:50 p.m., R69 went outside and ambulated with walker off the property, sat down on a bench and lit a cigarette. Noted a cigarette butt receptacle by the bench at this time. The facility's smoking policy dated 5/2019, indicated Parmly on the Lake is a smoke free campus. Policy prohibits smoking in any part of the building or on any part of the grounds. This includes the sidewalks, parking lots and driveways.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		10/18/24

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F 756	Continued From page 20 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the provider's response to the monthly medication review was followed for 1 of 4 (R18) residents with identified medication irregularities. Findings include:	F 756	F756 Drug Regimen Review, Report Irregular Medication recommendations for R18 was entered on 9/19 were immediately entered. All residents have the potential to be affected. Health Information Coordinators educated	

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F 756	Continued From page 21 R18's significant change Minimum Data Set (MDS) dated 8/27/24, indicated R18 was cognitively intact and had diagnoses of a right arm fracture, depression, and diabetes. R18 was continent of bowel and bladder and had frequent pain. R18's consultant pharmacist (CP) recommendation to physician dated 7/29/24, indicated R18 had requested a stool softener for hard stools and discomfort. R18 received scheduled MS contin (narcotic pain medication) and scheduled hydromorphone (narcotic pain medication) which can cause constipation. CP recommended initiating a bowel regimen as currently none was on file. CP also recommend the loperamide (medication to minimize loose BM) be discontinued if no longer needed. The provider responded to the recommendation on 9/16/24 and ordered senna (medication to prevent constipation) 8.6 milligrams (mg) daily and senna 8.6 mg daily as needed for constipation. R18's provider and nursing orders reviewed 9/19/24, lacked indication the facility had discontinued R18's loperamide order or implemented R18's provider orders for senna. When interviewed on 9/19/24 at 10:06 a.m., licensed practical nurse (LPN)-A stated nursing does not do much with the pharmacy recommendations. They go into a folder for the provider to review but wasn't sure what was done after the provider reviewed them. When interviewed on 9/19/24 at 1:27 p.m., the Director of Nursing (DON) verified R18's	F 756	on scanning process to ensure signed orders have a second nurse signature. Audits of transcribed orders will be completed weekly x4 then monthly x2 to ensure second nurse signature is present before scanning. 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 DON/Designee Date of Compliance: 10/18/2024	

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F 756	Continued From page 22 pharmacy recommendation to start a bowel regimen was provided on 7/29/24 and the provider completed a response on 9/16/24. The nurse consultant stated the providers have 60 days to respond or the CP will re-issue the recommendation. The nurse consultant verified the provider had written orders do discontinue the loperamide and to start senna daily and as needed, however the orders were not transcribed. DON stated the pharmacy recommendations were printed and given to the provider to review. After review from the provider, the DON expected the health information manager to transcribe the orders. The nurses do a second check and then the form was scanned into the medical record. An interview was attempted on 9/19/24, at 10:24 a.m., with the CP. There was no answer, and a voicemail was left. During a returned call on 9/20/24 at 11:05 a.m., the CP expected a provider to respond within 30-60 days of a recommendation. Furthermore, the CP expected the facility to implement the provider's response per their normal process for order entry. A facility policy titled Consultant Pharmacist Reports dated 5/2022, directed Recommendations are acted upon and documented by the facility staff and/or the prescriber.	F 756		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		10/18/24

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F 880	Continued From page 23 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.	F 880		

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F 880	Continued From page 24 (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 (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: Based on observation, interview and document review the facility failed to ensure staff performed the recommended hand hygiene for 1 of 2 residents (R77) reviewed who was on enteric precautions; and failed to ensure personal protective equipment (PPE) was utilized for 2 of 3 residents (R68 and R281) reviewed who had enhanced barrier precautions (EBP) in place. Additionally, the facility failed to ensure staff performed hand hygiene after changing soiled gloves for 1 of 1 residents (R74) reviewed for standard precautions with personal cares; and failed to ensure linens were covered during storage in the resident hallway. The uncovered linen had the potential to affect the 11 residents (including R82 and R83) residing in the southside transitional care unit.	F 880	F880 Infection Prevention & Control Education for all nursing staff will be provided on hand hygiene, also specifically for C-Diff and PPE for R77, R281, R74 and R39. Education for all nursing staff will be provided on Enhanced Barrier Precautions for R68. Appropriate linin storage was placed by blanket warmer for R82 and R83. All residents have the potential to be affected. Appropriate linin storage was placed by blanket warmer. Education on appropriate linin storage provided to all housekeeping and nursing staff. Education provided on Enhanced Barrier Precautions Policy, Transmission Based Precautions Policy,	

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F 880	Continued From page 25 Findings include: R77 R77's admission Minimum Data Set (MDS) dated 8/22/24, indicated severely impaired cognition. R77 had diagnoses of enterocolitis due to clostridium difficile, which is commonly known as c-diff, a bacterium that causes an infection of the colon; other fecal abnormalities, diarrhea, and dementia. It further indicated R77 required partial to moderate assistance with toileting, frequently incontinent of bladder, and always incontinent of bowel. R77's physician's orders dated 8/30/24, indicated Vancomycin HCl oral capsule 250 milligrams (mg). Give 250 mg by mouth four times a day for 14 Days and give 250 mg by mouth two times a day for 14 Days and give 250 mg by mouth one time a day related to C-diff, for 14 Days. R77's physician's orders lacked an order for contact enteric precautions. R77's care plan 8/18/24, indicated Isolation Precautions - enteric precautions related to c-diff Infection control precautions per protocol. It further included the following interventions; -sign on resident's door. -treatment for current infection per order. R77's progress note dated 9/18/2024 indicated the following: Infection Note-C-Diff Antibiotic Use: Vancomycin 250mg BID Stools including but not limited to Consistency, Frequency, Odor, Abdominal pain, cramps, signs/symptoms, dehydration: Resident continues	F 880	and Hand Washing Policy. Audits on appropriate hand washing, appropriate EBP usage, and appropriate Transmission Based Precautions usage weekly x4 then monthly x2. 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 DON/Designee Date of Compliance: 10/18/2024	

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F 880	Continued From page 26 to have loose stools, no other GI symptoms observed or reported. Number of loose stools: 1 large, loose Side effects of antibiotic use: : n/a Notification of change to provider, family/responsible party if applicable: not applicable During observation on 9/16/24 at 5:45 p.m., R77 was attempting to self transfer, surveyor went to get nursing assistant (NA)-G, who went into R77's room and assisted her into the bathroom. NA-G did not put on a gown or gloves before entering the room. After assisting R77 into the bathroom, NA-G exit the room and used hand sanitizer. Then NA-G went to the nursing station, wrote something down, and then went into R39's room (who was not on precautions) to answer her call light. She entered the room, adjusted the bedside table, and spoke to her for a few minutes before exiting the room. At 5:59 p.m. NA-G went back to R77's room and put on gloves and a gown before entering. NA-G assisted R77 out of the bathroom, removed gown and gloves, brought a bag of into the soiled utility room, and washed hands with soap and water. During interview on 9/16/24 at 6:09 p.m. NA-G verified R77 was on contact enteric precuations for C-diff, was still having loose stools, and wasn't wearing a gown or gloves. NA-G stated the reason for not wearing gown and gloves was because R77 was unable to self transfer and needed to get in the room quickly. NA-G also verified R77 had a sign on the door that indicated staff are required to wash their hands with soap and water when leaving R77's room but forgot and used hand sanitizer instead.	F 880		

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F 880	Continued From page 27 R68 R68's quarterly MDS dated 8/12/24, indicated severe cognitive impairment and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and chronic pain syndrome. It further indicated R25 had an impairment on the left side of her upper and lower extremities, was dependent on staff for most activities of daily living (ADL) and mobility, frequently incontinent of bladder and always incontinent of bowel. R25 was at risk for and had (1) unstageable pressure injury (coccyx) present on admission and a wound vacuum assisted closure (VAC). R68's physician's orders dated 7/19/24, indicated staff to follow EBP due to wound vacuum active closure (VAC). R68's care plan dated 4/30/24 indicated R68 was currently on EBP related to a wound. Staff to follow EBP. It further included the following interventions: -use appropriate communication to follow EBP. -explain reason for use of enhanced barrier precautions -staff to don/doff PPE per EBP when providing high contact cares. R68's nursing assistant care sheet (undated) indicated R68 was on EBP due to a wound on her coccyx. During observation on 9/16/24 at 3:21 p.m., licensed practical nurse (LPN)-A and NA-F brought R68 to her room to transfer her from her wheelchair to her bed. Upon entering the room, both staff applied gloves but did not don gowns.	F 880		

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F 880	Continued From page 28 They proceeded to transfer R68 from her wheelchair to her bed using the Hoyer lift and then they changed her brief. During interview on 9/17/24 at 3:48 p.m., NA-F stated R68 was on EBP because she had a wound. NA-F verified not wearing a gown while transferring R68 from the wheelchair to the bed (using the Hoyer lift) and changing her brief stating "I know she was on precautions, but I just spaced it (forgot)." During interview on 9/17/24 at 3:50 p.m., LPN-A verified R68 was on EBP but forgot to put on a gown because she didn't have a isolation cart outside her room. LPN-A stated they should have being wearing a gown while transferring R68 from her wheelchair to her bed and changing her brief. During interview on 9/18/24 at 8:27 a.m., NA-D stated staff are required to wear a gown and gloves when performing cares for residents on EBP. R281 R281's admission MDS dated 9/16/24, identified moderately impaired cognition. R281's undated diagnoses list included pneumonitis (inflammation of the lungs), dysphagia (abnormal swallowing), sepsis (infection of blood stream), gastronomy tube (tube inserted into stomach for feeding and medication administration). R281's careplan dated 9/18/24, identified assist of two for incontinence cares and ADLs, and EBP due to having gastronomy tube.	F 880		

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F 880	Continued From page 29 During an observation and interview on 9/18/24 at 8:50 a.m., NA-C stated they were about to begin morning cares for R281. NA-C wore a yellow isolation gown and gloves. NA-C washed R281's face with wet wash cloth. NA-C opened tabs of incontinence brief and pulled top of brief down exposing R281's peri area. NA-C sprayed cleansing spray on wash cloth and performed catheter/peri care using a clean area of the washcloth for each area. NA-C then removed gloves and applied new gloves without performing hand hygiene. NA-C then grabbed a package of disposable cleansing cloths and cleansed R281's groin area. NA-C removed gloves and, without sanitizing hands, activated call light to get assistance with positioning R281 on their side. NA-C then applied a new pair of gloves without sanitizing hands. A second staff member entered the room wearing yellow isolation gown and gloves to assist NA-C with repositioning R281. The 2nd staff member assisted with positioning R281 on their right side. While stabilizing R281 with left hand, NA-C noticed R218 had a bowel movement and pulled several disposable cleansing cloths out of the container. While the 2nd staff member stabilized R281 on their side, NA-C used right hand to spray cleansing spray onto disposable cloth in left hand. NA-C provided incontinence care using a clean area of disposable cloth with each wipe. Used disposable cloths were placed in incontinence product. NA-C continued providing incontinence care using right hand to spray cleansing spray into new wipe in left hand. NA-C removed gloves and, without performing hand hygiene, applied new gloves. Barrier cream was applied to R281's buttocks. NA-C removed gloves and donned new gloves, without hand hygiene. NA-C and 2nd staff	F 880		

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F 880	Continued From page 30 member applied and fastened new brief. NA-C then grabbed dirty brief and disposed of it in the garbage. NA-C then removed gloves and applied new gloves without hand hygrine. NA-C and 2nd staff member then repositioned R281 in bed, placed a pillow under knees, and straightened R281's catheter and gastronomy tube. NA-C removed gloves and asked surveyor if it was permissible to wash their hands in a resident's bathroom. NA-C then washed hands and applied new gloves. NA-C performed oral care for R281 using a cup of tap water and mouth swab. The second staff member then removed isolation gown and gloves before leaving the room. During interview, NA-C stated hand hygiene should be performed when entering and leaving a resident's room and confirmed they should have performed hand hygiene between glove changes however there was no sanitizer in R281's room and they did not have any on their person. They confirmed they should have used soap and water in absence of hand sanitizer. R74 R74's admission MDS dated 8/12/24, identified intact cognition and diagnoses of lung cancer, repeated falls, and weakness. R74 was incontinent and required assist of one for toileting. During an observation on 9/16/24 at 5:43 p.m., NA-E entered R74's room. NA-E performed hand hygiene and donned gloves. R74's blankets were pulled down. R74 was assisted to pull down pants and NA-E unfastened R74's brief. R74's brief was soiled with urine. NA-E tucked R74's brief down and a wipe was used to clean R74 from the front. NA-E then assisted R74 to turn towards the window removed R74's soiled brief and cleaned R74's backside. Without glove	F 880		

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F 880	Continued From page 31 exchange or hand hygiene, NA-E took the clean brief and tucked it under R74. R74 was then assisted to turn back onto their back. R74 was able to adjust himself so NA-E could finish pulling the brief through. NA-E fastened the brief and assisted with clothing and blankets. NA-E then removed their gloves and without performing hand hygiene moved to the head of the bed and pulled R74's draw sheet to boost R74 up. NA-E lowered R74's bed down, gave R74 the call light and adjusted R74's bedside table. NA-E then picked up R74's dinner tray and walked out of the room down the hallway to the dish cart before entering a staff area to obtain R74's tacos out of the fridge as requested. When interviewed on 9/16/24 at 5:59 p.m., NA-E verified they had not removed gloves and performed hand hygiene after removing R74's soiled brief. NA-E also verified they had not performed hand hygiene after exiting R74's room. NA-E further stated if they would have changed gloves if R74 had a bowel movement however wasn't aware they needed to for just urine and usually "we just wrap up the wet brief and keep going". LINEN STORAGE R82's face sheet dated 9/17/24, identified she required EBP due to wound care, and enteric precautions due to c-diff. R83's face sheet dated 9/17/24, identified she required EBP due to a history of MRSA, which stands for methicillin-resistant staphylococcus aureus; an infection from a type of staph bacteria resistant to many antibiotics. During an observation on 9/16/24 at 2:25 p.m.,	F 880		

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F 880	Continued From page 32 R82's room door was open, contact enteric precautions signage was present outside her room along with a covered PPE bin. Outside R82's door to her room in the hallway was a blanket warmer on a metal cart. There were several blankets stored uncovered on the middle shelf of the blanket warmer. During an observation on 9/17/24 at 1:40 p.m., two unknown staff donned PPE in the hallway outside R82's room, later exited the room and disinfected their transfer equipment in the hallway near the blanket warmer with uncovered blankets on the shelf. During an observation on 9/17/24 at 2:24 p.m., R82 had family members walking in and out of the room near the blanket warmer. Additionally, R83 had unknown therapy staff entering and exiting the room, which was also near the blanket warmer with uncovered blankets on the shelf beneath the warmer. During an interview 9/17/24 at 3:00 p.m., NA-B stated only staff restocked the blanket warmer and retrieved blankets it. NA-B stated she had not seen the blanket shelves covered. During an interview on 9/18/24 at 10:35 a.m., LPN-B verified the blankets were uncovered in the hallway, and stated it was not covered but should be. LPN-B stated laundry stocked the blankets on the shelf. During an interview on 9/19/24 at 10:50 a.m., the contracted housekeeping manager (HM) verified the blankets were stored uncovered in the hallway. The HM stated linens stored in the hallway should be covered to ensure cleanliness	F 880		

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F 880	Continued From page 33 of the linens. During an interview on 9/19/24 at 12:57 p.m., the infection preventionist (IP) stated she expected staff to wear a gown and gloves when entering a resident's room who is on isolation precautions. Staff were expected to use soap and water for hand hygiene upon exit of residents room who was positive for c.diff as hand sanitizer was not effective. IP further stated residents with wounds required staff to use EBP with any close contact care. Close contact care included transferring residents back to bed, repositioning and any personal cares and staff were expected to wear a gown and gloves when performing these cares for residents on EBP. Clean linens should be stored in clean storage rooms or were required to be covered if in the hallways. If not covered when in hallways, there was potential for the linens to come in contact with unclean items, residents, or visitors. The IP stated following these practices were important to minimize the risk of infections in the facility. A facility policy regarding handwashing as it pertains to C-diff was asked for but not received. The facility would follow the center for disease control (CDC) guidelines. A facility policy titled Transmission-Based Precautions revised 7/2023, directed staff to comply with TBP as per the guidance of the Centers for Disease Control (CDC). Contact precautions required the use of a gown and gloves upon entering the room or making contact with the resident or resident environment. Proper hand hygiene remained a key preventative measure regardless of the type of TBP needed.	F 880		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 A facility policy on Enhanced Barrier Precautions dated 4/1/24, indicated Enhanced barrier precautions refer to the use of gown and gloves for use during highcontact resident care activities for residents known to be colonized or with a multi drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). A facility policy titled Handwashing Policy revised 2/2024, directed staff to use proper handwashing to prevent the spread of infection. This included after changing incontinent products and after glove removal. The facility's policy titled Infection Prevention and Control Program dated 3/13/23, lacked direction for linen storage.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245328	A. BUILDING: **01 - MAIN BUILDING 01** B. WING	**9/17/2024**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 09/17/2024 at 11:14 AM, it was revealed by observation that the door to clean linen in Parkside would not latch due to missing hardware. Staff replaced the hardware at the time of the survey. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.

The above isolated deficiencies pose no actual harm to the residents

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 _____	**09/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/17/2024. 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	K 000		

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

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 _____	**09/17/2024**

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR 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.	K 000		

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K 000	Continued From page 2 The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		