Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2019

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

RE: Project Number H5328027C

Dear Administrator:

On March 7, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2019

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

RE: Project Numbers H5328025, H5328027C, H5328028C, H5328029C

Dear Administrator:

On January 24, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is March 5, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (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 (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" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 April 24, 2019 (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 July 24, 2019 (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: 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.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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 ______	C 01/24/2019

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
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted 1/24/19, to investigate complaints H5328025, H5328027C, H5328028C, H5328029C, Parmley on the Lake is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. H5328025 was found to be non- substantiated H5328027C was found to be substantiated at F689. H5328028C was found to be non-substantiated. H5328029C was found to be non-substantiated. The facility is enrolled in the electronic Plan of Correction (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 you acknowledge receipt of the electronic documents.	F 000		
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: Based on observation, interview and document review the facility failed to implement	F 689	This plan of correction constitutes our written allegation of compliance for the	2/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 02/13/2019

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 ______	C 01/24/2019

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
F 689	Continued From page 1 interventions to reduce the risk for falls for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's prospective payment system minimum data set dated 1/7/19, indicated she had intact cognition and required extensive assist of two staff for transfers and toileting. R1's Initial/Comprehensive Care Plan dated 10/8/18, identified a self care deficit related to weakness and falls. The care plan directed staff to provide extensive assist with mobility and identified the use of a wheel chair and walker. The care plan indicated staff assisted with transfers but did identify R1's transfer ability or level of assistance required. The care plan further identified a risk for falls and a history of falls and directed staff to ensure proper foot wear, notify nurse of falls and to keep the call light in reach. A care area assessment (CAA) dated 10/12/18, indicated R1 was at high risk for falls related to impaired mobility, history of falls and required assistance with transfers and ambulation and a history of falls prior to admission with noted injuries. The CAA indicated R1 was aware of limitations and indicated fall interventions were in place. Facility Progress Note dated 11/7/19, indicated R1 was lowered to the floor by staff. R1 slid on the bedroom floor and stated it was slippery. A correlating Incident Review and Analysis dated 11/7/18, indicated R1 was lowered to the floor by staff and indicated R1 did not have non-slip foot wear on when transferring. Interdisciplinary team in agreement that R1 was to have non-slip foot	F 689	deficiencies cited. Submission of this plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents or other individuals. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance. It is the protocol of Parmly on the Lake to identify residents at risk for falls and to implement fall prevention interventions. R1 was not being touched or transferred at the time of the resident's fall. R1 has discharged from the facility on 12/31/2018. Other residents who require physical assistance and assistive devices for transfers and ambulation may be affected by this practice. For those residents, falls risk assessments, care plans and assignment sheets will be reviewed and updated by the Director of Nursing and/or designee. The Transfer Belts, Mechanical Lift/Stand Policy was reviewed and remains current. Under the direction of the Director of Nursing, nursing staff will receive education about state and federal requirements for minimizing accidents and enhancing current compliant operations. The training for nursing staff will include the importance of using transfer belts as indicated on the plan of care/assignment sheets. A QAPI program was implemented under the supervision of the Director of Nursing to monitor transfers requiring assistance	

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 01/24/2019

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
F 689	Continued From page 2 wear on at all times when transferring. A facility Progress Note dated 12/16/18, indicated nursing staff yelled for nurse at 9:20 a.m. and upon entering room found R1 lying on her left side with her face on the ground. R1 was bleeding from a cut on the left side of her face above her eye. Nursing staff stated R1 was turning quickly when transferring back into chair, resdient got dizzy, lost her balance and slipped on the floor and fell. Writer noticed oxygen tubing tangled around R1's legs upon entering and R1 did have shoes on. R1 was sent to the hospital. A Progress Note dated 12/16/18, R1's daughter called and informed staff R1 had fractured ribs, nine stitches and scapula (shoulder blade) and clavicle (collar bone) fractures. A correlating Incident Review and Analysis dated 12/16/18, indicated R1 attempted to self transfer after nursing assistant asked her to wait for assistance as she was attempting to reposition oxygen tubing. R1 lost her balance and fell. R1 remained in the hospital. Interdisciplinary team in agreement that to prevent future occurrences, education for nursing staff to continue related to the policy and procedure for use of transfer belts. A History and Physical dated 12/16/18, indicated, fall with history of falls and balance problems. Fell while transferring from wheel chair to chair and fell forward striking her head and left side of her body. Patient reported history of falls, eight in the past year. X-ray showed distal clavicle fracture and possible scapular body fracture. CT of chest showed fracture of fourth, fifth and possible sixth left ribs. Suture repair of facial laceration.	F 689	and the use of transfer belts. The following systematic changes will be implemented: Audits will be completed for 6 residents across all shifts for 4 weeks to ensure all residents who require physical assistance and assistive devices for transfers and ambulation are receiving assistance based upon their care plans. Deficient practices will be corrected upon identification. The QAPI committee will review the compliance of each audit and will determine the need for continuation or adjustment of this plan of correction based on the compliance noted. DON and/or designee will be responsible.	

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 01/24/2019

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
F 689	Continued From page 3	F 689		

An Investigation Report Summary dated 12/21/18, indicated on 12/16/18, at 9:20 a.m. R1 had a fall in her room while nursing assistant (NA) was present. NA assisted R1 off the toilet and brought her from the bathroom to her recliner and placed her at an angle next to the chair. The report indicated the NA asked R1 to wait while she moved the oxygen tubing but R1 attempted to stand and fell. The NA stated she had not used the transfer belt.

During interview on 1/24/19, at 1:57 a.m. the director of nursing (DON) stated when interviewing the NA present at the time R1 fell, the NA stated she did not have a transfer belt on R1 and stated the NA told her she normally did not use a transfer belt for R1. The DON stated a transfer belt was a standard for any resident who required assistance during a pivot transfer and stated R1 should have had a transfer belt on. She stated all staff had been re-educated related to the use of transfer belts.

A facility policy titled Transfer Belt, Mechanical Lift/Stand dated 9/11, was reviewed. The policy indicated personnel are required to use transfer belts for residents who require assist with transferring or walking. The use of a transfer belt is necessary to prevent injury to both the resident and employee.

Electronically delivered
February 4, 2019

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

Re: State Nursing Home Licensing Orders - Project Numbers H5328025, H5328027C, H5328028C, H5328029C

Dear Administrator:

The above facility was surveyed on January 24, 2019 through January 24, 2019 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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 ______	C **01/24/2019**

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) 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: 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.	2 000		

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

Electronically Signed | | 02/13/19

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 ______	C 01/24/2019

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) COMPLETE DATE
2 000	Continued From page 1 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/24/19, surveyors of this Departments staff visited the above provider to investigate complaints #H5328025, H5328027C, H5328028C, H5328029C 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. H5328025 was found to be non- substantiated H5328027C was found to be substantiated at State tag 0830 H5328028C was found to be non-substantiated. H5328029C was found to be non-substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column	2 000		

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 ______	C 01/24/2019

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) COMPLETE DATE
2 000	Continued From page 2 and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	Corrected	2/22/19

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 ______	C 01/24/2019

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) COMPLETE DATE
2 830	Continued From page 3	2 830		

Continued From page 3

review the facility failed to implement interventions to reduce the risk for falls for 1 of 3 residents (R1) reviewed for accidents.

Findings include:

R1's prospective payment system minimum data set dated 1/7/19, indicated she had intact cognition and required extensive assist of two staff for transfers and toileting. R1's Initial/Comprehensive Care Plan dated 10/8/18, identified a self care deficit related to weakness and falls. The care plan directed staff to provide extensive assist with mobility and identified the use of a wheel chair and walker. The care plan indicated staff assisted with transfers but did identify R1's transfer ability or level of assistance required. The care plan further identified a risk for falls and a history of falls and directed staff to ensure proper foot wear, notify nurse of falls and to keep the call light in reach.

A care area assessment (CAA) dated 10/12/18, indicated R1 was at high risk for falls related to impaired mobility, history of falls and required assistance with transfers and ambulation and a history of falls prior to admission with noted injuries. The CAA indicated R1 was aware of limitations and indicated fall interventions were in place.

Facility Progress Note dated 11/7/19, indicated R1 was lowered to the floor by staff. R1 slid on the bedroom floor and stated it was slippery.

A correlating Incident Review and Analysis dated 11/7/18, indicated R1 was lowered to the floor by staff and indicated R1 did not have non-slip foot wear on when transferring. Interdisciplinary team in agreement that R1 was to have non-slip foot

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 ______	C 01/24/2019

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) COMPLETE DATE
2 830	Continued From page 4 wear on at all times when transferring. A facility Progress Note dated 12/16/18, indicated nursing staff yelled for nurse at 9:20 a.m. and upon entering room found R1 lying on her left side with her face on the ground. R1 was bleeding from a cut on the left side of her face above her eye. Nursing staff stated R1 was turning quickly when transferring back into chair, resdient got dizzy, lost her balance and slipped on the floor and fell. Writer noticed oxygen tubing tangled around R1's legs upon entering and R1 did have shoes on. R1 was sent to the hospital. A Progress Note dated 12/16/18, R1's daughter called and informed staff R1 had fractured ribs, nine stitches and scapula (shoulder blade) and clavicle (collar bone) fractures. A correlating Incident Review and Analysis dated 12/16/18, indicated R1 attempted to self transfer after nursing assistant asked her to wait for assistance as she was attempting to reposition oxygen tubing. R1 lost her balance and fell. R1 remained in the hospital. Interdisciplinary team in agreement that to prevent future occurrences, education for nursing staff to continue related to the policy and procedure for use of transfer belts. A History and Physical dated 12/16/18, indicated, fall with history of falls and balance problems. Fell while transferring from wheel chair to chair and fell forward striking her head and left side of her body. Patient reported history of falls, eight in the past year. X-ray showed distal clavicle fracture and possible scapular body fracture. CT of chest showed fracture of fourth, fifth and possible sixth left ribs. Suture repair of facial laceration. An Investigation Report Summary dated	2 830		

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 ______	C 01/24/2019

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) COMPLETE DATE
2 830	Continued From page 5 12/21/18, indicated on 12/16/18, at 9:20 a.m. R1 had a fall in her room while nursing assistant (NA) was present. NA assisted R1 off the toilet and brought her from the bathroom to her recliner and placed her at an angle next to the chair. The report indicated the NA asked R1 to wait while she moved the oxygen tubing but R1 attempted to stand and fell. The NA stated she had not used the transfer belt. During interview on 1/24/19, at 1:57 a.m. the director of nursing (DON) stated when interviewing the NA present at the time R1 fell, the NA stated she did not have a transfer belt on R1 and stated the NA told her she normally did not use a transfer belt for R1. The DON stated a transfer belt was a standard for any resident who required assistance during a pivot transfer and stated R1 should have had a transfer belt on. She stated all staff had been re-educated related to the use of transfer belts. A facility policy titled Transfer Belt, Mechanical Lift/Stand dated 9/11, was reviewed. The policy indicated personnel are required to use transfer belts for residents who require assist with transferring or walking. The use of a transfer belt is necessary to prevent injury to both the resident and employee. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident at risk for falls is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.	2 830		

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 ________	C **01/24/2019**

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) COMPLETE DATE
2 830	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		