Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 22, 2026

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

RE: CCN: 245328
Cycle Start Date: June 15, 2026

Dear Administrator:

On July 21, 2026, the Minnesota Department of Health 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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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July 22, 2026

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

Re: Reinspection Results
Event ID: 23561B-H2

Dear Administrator:

On July 21, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 15, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2026

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

RE: CCN:245328
Cycle Start Date: June 15, 2026

Dear Administrator:

On June 15, 2026, a 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 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:

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us

Office: (320) 223-7374 Mobile: (320) 423-061

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 15, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 15, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

June 30, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 23561B-H1

Dear Administrator:

The above facility survey was completed on June 15, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 2/10/26, 2/11/26, 2/12/26, and 2/15/26, a standard abbreviated survey was conducted at your facility. 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: H53282823C (3036695). As a result of the investigation deficiencies were cited at F684. F761, and F880. 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 that substantial compliance with the regulations has been attained.	F0000		06/12/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals	F0761	Medication carts at the crosswalk of Parkside Nurses Station and Southside unit adjacent to the day room were locked. Medication Storage in the Facility policy was reviewed and remains current. Education related to Medication Storage, including locking carts when leaving unattended was provided to all licensed nurses and TMA staff. Date of Compliance: 6/12/2026 Audits of all medication carts will be completed	06/12/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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F0761 SS = E	Continued from page 1 in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review the facility failed to ensure medications were stored securely to ensure residents, staff and guests could not access medications in 2 of 2 medication carts observed, potentially affecting two units of the facility, with 43 residents. Findings include: During a continuous observation on 6/10/26 from 4:07 p.m. to 4:15 p.m., the medication cart at the crosswalk of the Parkside nurses' station, was left unlocked and unattended. Staff walked by the medication cart five times, and one resident wheeled by in a wheelchair. During an interview on 6/10/26 at 4:15 p.m., the registered nurse (RN)-E stated he walked away from the medication cart to administer a treatment to a resident and forgot to lock it. The RN-E acknowledged he could not see the medication cart from the resident's room and the medication cart was supposed to be locked when he walked away from it. The RN-E stated it was a risk to patients because their medications could be taken from the cart and also staff could steal medications. During an observation on 6/12/26 at 3:01 p.m., the medication cart on the Southside unit adjacent to the day room was unattended and unlocked. Three residents and six staff walked by. During an interview on 6/12/26 at 3:05 p.m., the RN-F stated she was just in another room counting medications with another nurse while the medication cart was left unattended and unlocked. The RN-F acknowledged she could not see the cart from the other room and knew staff and residents had walked by the cart. RN-F stated the cart was supposed to	F0761	Continued from page 1 weekly x4 then monthly x2 months to ensure medications carts are locked when unattended. 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 or designee	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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Parmly on the Lake LLC	**28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013**

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F0761 SS = E	Continued from page 2 be locked when she walked away from the cart or someone could steal medications. During an interview on 6/15/26 at 10:55 a.m., the director of nursing (DON) stated nurses were expected to lock medication carts any time they were not directly in front of the medication cart to prevent theft. Further, the DON stated medications in a capsule required a provider order to open the capsule and administered the contents without the capsule, and medications in a capsule could not be divided equally and accurately. The Medication Storage in the Facility policy dated May 2022 indicated the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication carts were locked when not attended by people with authorized access.	F0761		06/12/2026
F0684 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 observation, interviews, and document review, the facility failed to ensure skin assessments were performed as ordered for 1 of 3 residents (R3) reviewed for wound care. Additionally, the facility failed to ensure medication orders were followed for 2 of 2 residents (R4, R5) when saccharomycin (a probiotic yeast used to support digestive health and treat gastrointestinal – stomach and intestine- issues) was not administered as prescribed. Findings include: R3 R3’s significant change Minimum Data Set (MDS) dated 4/20/26, indicated R3 was dependent on staff for activities of daily living (ADLs), and was at risk of	F0684	R3’s skin assessment was completed. R4 and R5’s saccharomycin was administered. All residents were audited to ensure skin checks were completed. Residents ordered for saccharomycin were audited and ensured medication was available and administered. An audit of missed medications was completed to address any other medications not administered. Skin Assessment and Wound Management Policy was reviewed and remains current. Medication and Treatment Order Policy was reviewed and remains current. Education related to weekly skin checks was provided to all Licensed Nurses and Clinical Managers. Education related to Medication availability and administration was provided to all Licensed Nurses, TMAs, and Clinical Managers. Date of Compliance: 6/12/2026 Audits of 5 residents will be completed weekly x4 then monthly x2 months to ensure skin assessments are completed. Audits of missed medications will be completed weekly x4 then monthly x2 months to ensure medications are administered and any note of unavailable medications are followed with in a timely manner. The results of these audits will be shared with the	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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F0684 SS = D	Continued from page 3 developing additional pressure ulcers. R3's diagnoses included cancer, heart failure, malnutrition, diabetes, arthritis, end stage kidney disease, and respiratory failure. R3's care plan indicated the following: 3/11/26, monitor for skin breakdown and for signs and symptoms of infection 4/22/26, an alteration in skin integrity related to abrasion on buttock R3's provider orders dated 3/31/26, indicated starting 4/6/26 at 2:30 p.m., licensed nurses to perform weekly skin inspections every Monday evening. R3's Monarch Health Management (MHM) Weekly Skin Assessments in the electronic health record (EHR) indicated weekly skin assessments were completed 4/6/26, 4/21/26, 5/3/26, 5/4/26, 5/11/26, 5/18/26, 5/25/26, and 5/31/26. The EHR lacked indication weekly skin assessments were completed the weeks of 3/29/26, 4/12/26, 4/26/26, and 6/8/26, and R3 refused the skin assessment on 3/28/26 and 5/4/26. R3's April 2026 Treatment Administration Record (TAR) indicated weekly skin inspections by a licensed nurse were to be completed every Monday evening shift, complete MHM Weekly Skin Inspection form in the medical record. The TAR indicated the skin inspections were omitted 4/13/26 and 4/27/26. R3's May 2026 TAR indicated weekly skin inspections by a licensed nurse were to be completed every Monday evening shift, complete MHM Weekly Skin Inspection form in the medical record. The TAR indicated the skin inspection was omitted 5/18/26. R3's June 2026 TAR indicated weekly skin inspections by a licensed nurse were to be completed every Monday evening shift, complete MHM Weekly Skin Inspection form in the medical record. The TAR indicated the skin inspection was omitted 6/8/26.	F0684	Continued from page 3 facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or designee	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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

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F0684 SS = D	Continued from page 4 During an interview on 6/11/26 at 1:50 p.m., the licensed practical nurse (LPN)-C stated skin assessments were performed once weekly, and if the resident refused, the nurse was supposed to tell the subsequent shift nurse. If the assessment still was not completed on the scheduled day, the nurses could ask a nurse manager for assistance. The LPN-C stated she did not recall R3 ever refusing care. The LPN-C acknowledged she did not see a skin assessment for R3 in the admission assessment, and R3 was missing weekly assessments the weeks of 3/29/26, 4/12/26, 4/26/26, and 6/8/26. The LPN-C further acknowledged on 6/8/26, the TAR referred to a nursing note for explanation, but there was no nursing note to explain why the skin assessment was not completed. The LPN-C stated staff should have been monitoring R3's skin for breakdown. During an interview on 6/11/26 at 2:08 p.m., the registered nurse (RN)-C stated R3 had weekly skin assessments, or more frequently if skin issues were noted by a nursing assistant (NA) and then the nurse was required to assess the skin to observe what the NA found. The RN-C acknowledged R3 had a wound on her bottom, was incontinent, frail, slid around in her bed, had poor nutritional intake and could have skin changes as a result. During an interview on 6/11/26 at 2:20 p.m., the RN-D stated when skin assessments were not completed as ordered, the resident could have skin breakdown and wounds that were not noticed timely. On 6/11/26 at 3:00 p.m., the RN-H stated the purpose of weekly skin assessments was to observe a resident's skin to ensure there were no new skin issues, and to document the findings. The purpose of the weekly wound rounds was to assess the skin issues that were already known. The weekly skin assessments and weekly wound rounds were not used interchangeably. During an interview on 6/12/26 at 12:06 p.m., the RN-B stated R3 was supposed to have weekly skin assessments. If R3 wasn't getting weekly skin assessments she could have undiagnosed skin issues or unseen evidence of abuse. The RN-B stated she was not aware of any instance in which R3 refused the weekly skin assessments.	F0684		06/12/2026

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Parmly on the Lake LLC	**28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013**

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F0684 SS = D	Continued from page 5 During an interview on 6/15/26 at 10:55 a.m., the director of nursing (DON) stated weekly wound rounds were utilized weekly to assess for and monitor for skin integrity and acknowledged R3's weekly skin assessments were not completed as ordered. The Skin Assessment and Wound Management policy dated 2/2025 indicated licensed staff would perform a weekly skin inspection. R4 R4's quarterly MDS dated 3/24/26, indicated intact cognition, and dependence upon staff for ADLs. R4's diagnose included trauma from a motor vehicle accident, a traumatic brain injury, and altered mental status. R4's care plan indicated the following: 12/19/25, alteration in elimination related to diarrhea and malnutrition with an intervention to monitor bowel movements as they occur The care plan lacked mention of the use of saccharomycin to treat diarrhea. R4's provider orders dated 4/20/26, indicated saccharomycin oral capsule 250 mg (milligrams), give by mouth two times daily related to enterocolitis (inflammation of the intestines) due to clostridium difficile (C-Diff - a bacterium that causes severe, watery diarrhea and inflammation of the colon). R4's May 2026 Medication Administration Record (MAR) indicated administer saccharomycin 250 mg twice daily in the morning and at bedtime. The MAR indicated the medication was not administered as ordered on 5/28/26 and 5/30/26 at bedtime. R4's progress notes dated 5/28/26 at 8:00 p.m., and 5/30/26 at 7:46 p.m., indicated saccharomycin was not administered because the medication was not available. R4's June 2026 MAR indicated administer saccharomycin 250 mg twice daily in the morning	F0684		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 6 and at bedtime. The MAR indicated the medication was not administered as ordered on 6/2/26, 6/3/26, 6/8/26, and 6/9/26 at bedtime. R4's progress notes dated 6/2/26 at 8:35 p.m., 6/3/26 at 8:44 p.m., 6/8/26 at 9:41 p.m., and 6/9/26 at 7:26 p.m., indicated saccharomycin was not administered because the medication was not available. R5 R5's annual MDS dated 6/2/26, indicated moderate cognitive impairment, dependence upon staff for assistance with ADLs. R5's diagnoses included heart failure, dementia, stroke, malnutrition, an indwelling urinary catheter, and frequent incontinence of bowel. R5's care plan dated 11/12/25, indicated an alteration in elimination related to a history of C-Diff. The care plan lacked mention of the use of saccharomycin to treat diarrhea. R5's provider orders dated 3/12/26, indicated saccharomycin oral capsule 250 mg, give by mouth two times daily related to enterocolitis due to recurrent clostridium difficile. R5's May 2026 MAR indicated administer saccharomycin 250 mg twice daily in the morning and at bedtime. The MAR indicated the medication was not administered as ordered on 5/28/26 and 5/30/26 at bedtime. R5's progress notes dated 5/28/26 at 7:49 p.m., and 5/30/26 at 7:06 p.m., indicated saccharomycin was not administered because the medication was not available. R5's June 2026 MAR indicated administer saccharomycin 250 mg twice daily in the morning and at bedtime. The MAR indicated the medication was not administered as ordered on 6/2/26, 6/8/26, and 6/9/26 at bedtime. R5's progress notes dated 6/2/26 at 6:43 p.m.,	F0684		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

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F0684 SS = D	Continued from page 7 6/8/26 at 10:26 p.m., and 6/9/26 at 9:26 p.m., indicated saccharomycin was not administered because the medication was not available. During an interview on 6/11/26 at 3:09 p.m., the DON stated the carts did contain the correct dose of saccharomycin. The bottle was labeled to give 1-2 capsules, and the total unit dose was 500 mg, meaning each capsule contained 250 mg. The DON acknowledged the packaging on the bottle was confusing for some of the nurses, and stated she would provide education to nurses about the packaging and dosing. The DON acknowledged R4 and R5 each missed doses of saccharomycin, perhaps due to the confusion with the medication label. During an interview on 6/12/26 at 2:54 p.m., the RN-G stated she did not have the correct dose of saccharomycin for R4. R4 was supposed to get 250 mg twice a day, and the bottle in the cart was 500 mg capsules, which could not be crushed. The RN-G stated she took one capsule, opened it, divided the contents into two medication cups, mixed one cup with applesauce and administered it to R4, and then discarded the second cup. The RN-G stated she did not need an order to open the medication capsule for administration and had been doing it that way for ten years, so she knew it was all right to do that and stated the dose was easily divided by looking at the quantity of the contents in the dose cups. During an interview on 6/12/26 at 2:33 p.m., the LPN-A stated the facility did not have the correct dose of saccharomycin for residents. Residents typically had orders for 250 mg twice daily but the stock medication came in 500 mg capsules instead of 250 mg. The LPN-A stated it appeared some staff were giving the medication anyway, but it was not the correct dose if they were. The LPN-A further stated she asked other nurses who showed her they were giving the 250 mg doses from the stock medication bottles labeled 500 mg, and sometimes the LPN-A found 250 mg doses that came in bottles from the pharmacy and would administer those when they were available. During an interview on 6/12/26 at 1:17 p.m., the LPN-B stated two residents, R4 and R5, did not get saccharomyces doses because the facility did not have the correct doses on hand, the bottles were	F0684		06/12/2026

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F0684 SS = D	Continued from page 8 labeled 500 mg, not 250 mg, and the medication was not available in the facility medication bank. The LPN-B stated she noticed the residents were administered the medication on other dates and didn't know why she did not have the correct medication in the medication cart when other nurses had administered it previously. The LPN-B acknowledged she asked other nurses about the medication and was told it was in her cart, but she did not find it and did not give saccharomyces as ordered for R4 and R5. During an interview on 6/15/26 at 11:57 a.m., the medical director (MD) stated if a medication was ordered, it should have been administered. If staff had a question about the label on a medication, they should have asked a nurse manager or the pharmacist. The MD also stated if a nurse opened a capsule and administered half of the contents, that would be a medication error and should be recorded as such. The Medication Administration Guidelines policy dated 5/22 indicated the right dose would be administered for each medication ordered. Opening capsules may require a physician's order, according to facility policy. If it is safe to do so, capsules may be emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines. An individualized approach should be used when altering dosage forms opening capsules. Working with the resident or representative and appropriate clinicians (e.g., the consultant pharmacist, attending physician, medical director) the facility should determine the most appropriate method for administering medications which considers each resident's safety, needs, medication schedule, preferences, and functional ability.	F0684		06/12/2026
F0880 SS = D	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 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	RN-A received education on infection control procedures as it related to hand hygiene and wound care. Infection Control and Prevention Policy was reviewed and remains current. Education related to Infection Control and Prevention as it relates to hand hygiene and infection prevention during wound care was provided to all Licensed Nurses.	06/12/2026

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F0880 SS = D	Continued from page 9 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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.	F0880	Continued from page 9 Date of Compliance: 6/12/2026 Audits of 5 residents' nurse hand hygiene procedures during wound care will be completed weekly x4 then monthly x2 months to ensure proper infection control procedures. 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 or designee	06/12/2026

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F0880 SS = D	Continued from page 10 §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 observations, interviews, and document review, the facility failed to maintain an effective infection prevention and control program by ensuring staff utilized proper hand hygiene during wound care treatments for 1 of 1 resident (R3) observed for wound care. Findings include: R3's significant change Minimum Data Set (MDS) dated 4/20/26, indicated R3 was dependent on staff for activities of daily living (ADLs) was was at risk of developing additional pressure ulcers. R3's diagnoses included cancer, heart failure, malnutrition, diabetes, arthritis, end stage kidney disease, and respiratory failure. R3's care plan indicated the following: 3/11/26 an alteration in skin integrity related to abrasion on buttock with an intervention to monitor for skin breakdown and for signs and symptoms of infection 3/19/26 enhanced barrier precautions (EBP-an infection control strategy that requires staff to wear gowns and gloves during high-contact care to prevent the spread of drug-resistant organisms) related to the coccyx wound with an intervention to don and doff personal protective equipment per EBP precautions R3's wound care orders indicated the following: 4/22/26 staff to follow enhanced barrier precautions for wound care 5/22/26 wound care to the coccyx moisture associated skin damage (MASD): cleanse with wound cleanser, pat dry, apply calmoseptine (barrier	F0880		06/12/2026

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F0880 SS = D	Continued from page 11 cream to prevent moisture on the skin) twice daily and as needed During an observation on 6/10/26 at 11:39 a.m., the registered nurse (RN)-A provided wound care for R3. Afterwards, The RN-A doffed her gloves, donned a clean pair and applied barrier cream to R3's bottom. The RN-A doffed her gloves again, donned a clean pair of gloves, and repositioned R3 in bed and arranged items on R3's tray table. The RN-A did not perform hand hygiene between either glove change. During an interview on 6/10/26 at 11:50 a.m., the RN-A acknowledged she knew she was supposed to perform hand hygiene between both glove changes to prevent the spread of infection but had not because she forgot. During an interview on 6/15/26 at 10:55 a.m., the director of nursing (DON) stated when performing wound care, the nurses were required to perform hand hygiene between gloves changes to prevent infection or the spread of germs. The Handwashing policy dated 2/24 indicated when conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.	F0880		06/12/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/10/26, 2/11/26, 2/12/26, and 2/15/26 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no	20000		06/12/2026

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

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20000	Continued from page 1 deficiency issued: H53282823C (3036695). As a result of the investigation a licensing order was issued at 1610. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		06/12/2026
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.	21610	Medication carts at the crosswalk of Parkside Nurses Station and Southside unit adjacent to the day room were locked. Medication Storage in the Facility policy was reviewed and remains current.	06/12/2026

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21610	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review the facility failed to ensure medications were stored securely to ensure residents, staff and guests could not access medications in 2 of 2 medication carts observed, potentially affecting two units of the facility, with 43 residents. Findings include: During a continuous observation on 6/10/26 from 4:07 p.m. to 4:15 p.m., the medication cart at the crosswalk of the Parkside nurses' station, was left unlocked and unattended. Staff walked by the medication cart five times, and one resident wheeled by in a wheelchair. During an interview on 6/10/26 at 4:15 p.m., the registered nurse (RN)-E stated he walked away from the medication cart to administer a treatment to a resident and forgot to lock it. The RN-E acknowledged he could not see the medication cart from the resident's room and the medication cart was supposed to be locked when he walked away from it. The RN-E stated it was a risk to patients because their medications could be taken from the cart and also staff could steal medications. During an observation on 6/12/26 at 3:01 p.m., the medication cart on the Southside unit adjacent to the day room was unattended and unlocked. Three residents and six staff walked by. During an interview on 6/12/26 at 3:05 p.m., the RN-F stated she was just in another room counting medications with another nurse while the medication cart was left unattended and unlocked. The RN-F acknowledged she could not see the cart from the other room and knew staff and residents had walked by the cart. RN-F stated the cart was supposed to be locked when she walked away from the cart or someone could steal medications. During an interview on 6/15/26 at 10:55 a.m., the director of nursing (DON) stated nurses were expected to lock medication carts any time they were not directly in front of the medication cart to prevent theft. Further, the DON stated medications in a capsule required a provider order to open the capsule and administered the contents without the capsule, and medications in a capsule could not be divided equally and accurately.	21610	Continued from page 2 Education related to Medication Storage, including locking carts when leaving unattended was provided to all licensed nurses and TMA staff. Date of Compliance: 6/12/2026 Audits of all medication carts will be completed weekly x4 then monthly x2 months to ensure medications carts are locked when unattended. 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 or designee	06/12/2026

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21610	Continued from page 3 The Medication Storage in the Facility policy dated May 2022 indicated the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication carts were locked when not attended by people with authorized access. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21610		06/12/2026