



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
October 9, 2023

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

RE: CCN: 245328  
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 21, 2023, we notified you a remedy was imposed. On October 4, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 25, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 6, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 21, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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](mailto:Melissa.Poepping@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Submitted  
September 21, 2023

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

RE: CCN: 245328  
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 8, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On September 8, 2023, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

#### REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 6, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 6, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 6, 2023, (42 CFR 488.417 (b)).

Parmly On The Lake LLC

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You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 8, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Parmly On The Lake Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 8, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

#### DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor  
Metro A District Office  
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: 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 their 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

Parmly On The Lake LLC

September 21, 2023

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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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 8, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

#### APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov)

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an

Parmly On The Lake LLC

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appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

#### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

#### 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](https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm)

Parmly On The Lake LLC

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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 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](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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name being more prominent.

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](mailto:Melissa.Poepping@state.mn.us)



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Electronically delivered

September 21, 2023

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

Re: Event ID: YVLF11

Dear Administrator:

The above facility survey was completed on September 8, 2023 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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](mailto:Melissa.Poepping@state.mn.us)

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

PRINTED: 09/22/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/08/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARMLY ON THE LAKE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD</b> <b>CHISAGO CITY, MN 55013</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>On 9/6/23-9/8/23, 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.</p> <p>The following complaints were reviewed: H53285065C (MN00964070) with a deficiency cited at F580 and F684. The survey resulted in an Immediate Jeopardy (IJ) at F684 when for R1 required emergent care 2 days after a witnessed fall and was diagnosed with displaced rib fractures, chest wall hematoma (blood collection outside of large vessels) and hemothorax (blood accumulation between the chest wall and lungs). The IJ began on 6/30/23, and the immediacy was removed on 9/8/23. The above findings constituted substandard quality of care, and an extended survey was conducted on 9/8/23.</p> <p>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.</p> <p>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.</p>	F 000			
F 580 SS=D	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes.</p>	F 580		9/8/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/2023

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.

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

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NAME OF PROVIDER OR SUPPLIER  <b>PARMLY ON THE LAKE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD</b> <b>CHISAGO CITY, MN 55013</b>		
(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 580	<p>Continued From page 1</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15)</p>	F 580		

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F 580	<p>Continued From page 2</p> <p>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to notify the medical provider regarding a fall and injuries sustained for 1 of 3 residents (R1) reviewed for falls.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 6/3/23, indicated R1 had severe cognitive impairment, required extensive assistance with one person and a walker for mobility and had a history of falls. Furthermore, R1's MDS indicated R1 received an anticoagulant (blood thinning medication) and had diagnoses of spinal fusion, arterial flutter (rapid heartbeat), and cerebral hemorrhage (brain bleed).</p> <p>A review of R1's provider orders indicated the following: -an order on 6/12/23, indicated R1 required immediate provider notification for falls and head strikes every shift related to R1's anticoagulant use.</p> <p>A review of R1's progress notes dated 6/30/23 to 7/2/23, lacked any indication the medical provider was notified after the witnessed fall on 6/30/23.</p> <p>R1's nursing progress note dated 7/2/23 at 6:48</p>	F 580	<p>R1 has been discharged from the facility.</p> <p>All like residents who have had recent falls the last 14 days were reviewed to ensure their health status monitoring was completed, assessments and care plan reviewed and updated. Residents <input type="checkbox"/> physicians have been notified of post fall.</p> <p>The DON or designee will provide re-education to all nurse managers, licensed nurses and CNAs on Fall Policies and Procedures pertaining to completing assessments, monitoring injuries and health status along with physician notification post fall prior to the start of their next shift via google docs/email acknowledgement, phone call or in-person sign off.</p> <p>The DON or designee will complete audits daily for 1-week, weekly x 4 and then monthly x2. Audits will include education to appropriate staff on fall policies and procedures pertaining to completing assessments, monitoring injuries and health status, along with physician notification post fall. Audits will include recent falls to ensure the resident health</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 580	<p>Continued From page 3</p> <p>p.m., indicated the previous shift reported R1 was very tired and sleeping most of the day due to being "up all night". R1's wife notified nurse something was wrong. Upon assessment, R1 "appeared very lethargic and was slow to respond and unable to open eyes fully." R1's neurological status and vital signs were obtained and the note indicated they were within normal limits. R1 complained of back pain and rib pain related to the fall on 6/30/23. R1's provider was notified and R1 was sent to hospital for evaluation due to R1's fall history on 6/30/23, anticoagulant therapy, and history of brain bleed.</p> <p>R1's chest computerized tomography scan (CT scan) results dated 7/2/23, (no time) indicated R1 had displaced back left 10th and 11th rib fractures and non-displaced back left 10th -12th rib fractures, chest wall hematoma near the fracture sites, and a large left pleural effusion (accumulation of excess fluid in the space between the lung and chest wall).</p> <p>R1's Emergency department progress note dated 7/3/23 at 12:52 a.m., indicated R1 was seen in the emergency room due to altered mental status. Per report, R1 had a fall back into a radiator two days ago and had complained of back and rib pain. R1 had a wet sounding cough, was lethargic and slow to answer, but was responding to questions. R1's hemoglobin (lab that determines blood loss) dropped 2 grams (g) from previous result two weeks ago. R1's diagnoses included multiple rib fractures and hemothorax. R1's note further indicated after discussion with R1's family, it was determined a transfer to trauma hospital for chest tube (tube inserted into the chest wall to drain plural effusion and treat hemothorax) was not desired and R1</p>	F 580	<p>status monitoring is completed, assessments and care plan is reviewed and updated. Audits will also include a review that physicians have been notified. Audit results will be reviewed by the QAPI Committee for further recommendations.</p>	

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

PRINTED: 09/22/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/08/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARMLY ON THE LAKE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD</b> <b>CHISAGO CITY, MN 55013</b>		
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F 580	<p>Continued From page 4</p> <p>would be comfort care and transition to hospice. R1 expired 10 days after hospitalization.</p> <p>The facility's internal investigation dated 7/2/23, indicated nursing assistant (NA)-B reported walking R1 to the bathroom on 6/30/23 at 10:30 p.m., and R1 stumbled backwards into a radiator and wall outlet. NA-B was able to guide R1's head to avoid head injury but was unable to prevent the fall. Incident was reported to registered nurse (RN)-C. The internal investigation did not indicate the provider was notified at the time of the fall.</p> <p>R1's medical record also lacked indication a staff member notified R1's provider of the incident between the time of the incident on 6/30/23, until R1 was sent to hospital for evaluation on 7/2/23.</p> <p>When interviewed on 9/7/23 at 9:17 a.m., medical doctor (MD)-A could not find any documentation of R1's fall when reviewing R1's provider and on call documentation. MD-A further stated there was no provider notes or on call documentaion for R1 from 6/27/23 until R1's hospitalization on 7/2/23.</p> <p>When interviewed on 9/7/23 at 9:45 a.m., MD-A stated they expected staff to notify providers right away of residents who fall and were also taking an anticoagulant. Staff were also expected to monitor for bruising, pain, and injury post fall. Furthermore, the medical director expected staff to notify providers if any abnormal assessments or changes after a fall.</p> <p>When interviewed on 9/7/23 at 12:55 p.m., the DON stated initially an internal investigation was started however, was not completed due to a lack in communication. DON had completed further</p>	F 580		

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F 580	<p>Continued From page 5</p> <p>interviews and follow up today after state surveyors entered. DON further stated R1 had a witnessed fall and when the details of the incident are known, a risk analysis wasn't required. DON expected staff to notify the family and provider, on call leader and complete a thorough assessment, including a skin assessment, initiate "post fall order"s after every resident fall to ensure assessments and monitoring for injury were completed.</p> <p>When interviewed on 9/8/23 at 2:09 p.m., RN-C stated NA-B reported R1 had misstepped and fell against the wall and maybe hit something and RN-C felt it was not a "true fall" since it was witnessed and therefore RN-C did not feel the fall required provider notification.</p> <p>A facility policy titled Fall Prevention and Management revised 2/2021, directed staff to: -notify the provider in a timely manner for any residents noted to be on an anticoagulation as there was significant risk of bleeding. -document the relevant details of the fall. -observe for delayed complications of a fall (72) hours after an observed or suspected fall and will document in the medical record. Documentation will include vital signs, pain, swelling, bruising, decreased mobility, and overall function. -nursing staff will complete and incident review and analysis.</p> <p>A facility policy titled Change in Resident's Condition revised (no date), directed staff to notify the attending physician or physican on call if there was a resident incident/accident and if there was specific instructions to notify the provider.</p>	F 580		
F 684 SS=J	Quality of Care	F 684		9/8/23

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F 684	<p>Continued From page 6 CFR(s): 483.25</p> <p>§ 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 comprehensively assess and monitor for signs of injury after a fall, resulting in delayed diagnosis and treatment for injuries for 1 of 3 residents (R1) reviewed for delay in treatment. This resulted in an immediate jeopardy (IJ) for R1 who required emergent care and hospitalization as a result of their injuries.</p> <p>The immediate jeopardy began on 6/30/23, when R1 was not assessed for any injuries after a witnessed fall, that resulted in displaced rib fractures, chest wall hematoma (blood collection outside of large vessels) and hemothorax (blood accumulation between the chest wall and lungs). The administrator and director of nursing (DON) were notified of the IJ on 9/7/23, at 2:45 p.m. The IJ was removed on 9/8/23 at 2:35 p.m., but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:  R1's admission Minimum Data Set (MDS) dated</p>	F 684	<p>R1 has been discharged from the facility.</p> <p>All like residents who have had recent falls the last 14 days were reviewed to ensure their health status monitoring was completed, assessments and care plan reviewed and updated. Residents <input type="checkbox"/> physicians have been notified of post fall.</p> <p>The DON or designee will provide re-education to all nurse managers, licensed nurses and CNAs on Fall Policies and Procedures pertaining to completing assessments, monitoring injuries and health status along with physician notification post fall prior to the start of their next shift via google docs/email acknowledgement, phone call or in-person sign off.</p> <p>The DON or designee will complete audits daily for 1-week, weekly x 4 and then monthly x2. Audits will include education to appropriate staff on fall policies and procedures pertaining to completing assessments, monitoring injuries and</p>	

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F 684	<p>Continued From page 7</p> <p>6/3/23, indicated R1 had severe cognitive impairment, required extensive assistance with one person and a walker for mobility and had a history of falls. Furthermore, R1's MDS indicated R1 received an anticoagulant (blood thinning medication) and had diagnoses of spinal fusion, arterial flutter (rapid heartbeat), and cerebral hemorrhage (brain bleed).</p> <p>A review of R1's provider orders indicated the following: -an order on 6/3/23, indicated R1 required Eliquis (anticoagulant medication) 5 milligrams (mg) twice daily for arterial flutter. -an order on 6/12/23, indicated R1 required monitoring for black tarry stools, severe headache, nausea, vomiting, lethargy, and bruising every shift related to R1's anticoagulant use. -an order on 6/12/23, indicated R1 required immediate provider notification for falls and head strikes every shift related to R1's anticoagulant use.</p> <p>A review of R1's electronic medication administration record (EMAR) progress notes indicated: -on 6/30/23 at 11:05 p.m., R1 was administered Tylenol for general pain. -on 7/1/23 at 5:18 a.m., R1 requested Tylenol for pain. -on 7/1/23 at 1:18 p.m., R1 was administered Tylenol for back pain. -on 7/1/23 at 7:54 p.m., R1 was administered Tylenol for headache/neck pain. -on 7/2/23 at 12:36 a.m., R1 was administered Tylenol for back pain rated 9/10. The EMAR lacked any indication of monitoring for bleeding, bruising, or any injuries.</p>	F 684	<p>health status, along with physician notification post fall. Audits will include recent falls to ensure the resident health status monitoring is completed, assessments and care plan is reviewed and updated. Audits will also include a review that physicians have been notified. Audit results will be reviewed by the QAPI Committee for further recommendations.</p>	

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F 684	<p>Continued From page 8</p> <p>A review of R1's progress notes dated 6/30/23 to 7/2/23, lacked any indication a comprehensive assessment for evaluation of potential injuries or any ongoing monitoring for injuries was completed after the witnessed fall on 6/30/23.</p> <p>R1's nursing progress note dated 7/2/23 at 6:48 p.m., indicated the previous shift reported R1 was very tired and sleeping most of the day due to being "up all night". R1's wife notified nurse something was wrong. Upon assessment, R1 "appeared very lethargic and was slow to respond and unable to open eyes fully." R1's neurological status and vital signs were obtained and the note indicated they were within normal limits. R1 complained of back pain and rib pain related to the fall on 6/30/23. R1's provider was notified and R1 was sent to hospital for evaluation due to R1's fall history on 6/30/23, anticoagulant therapy, and history of brain bleed.</p> <p>R1's chest computerized tomography scan (CT scan) results dated 7/2/23, (no time) indicated R1 had displaced back left 10th and 11th rib fractures and non-displaced back left 10th -12th rib fractures, chest wall hematoma near the fracture sites, and a large left pleural effusion (accumulation of excess fluid in the space between the lung and chest wall).</p> <p>R1's Emergency department progress note dated 7/3/23 at 12:52 a.m., indicated R1 was seen in the emergency room due to altered mental status. Per report, R1 had a fall back into a radiator two days ago and had complained of back and rib pain. R1 had a wet sounding cough, was lethargic and slow to answer, but was responding to questions. R1's hemoglobin (lab</p>	F 684		

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F 684	<p>Continued From page 9</p> <p>that determines blood loss) dropped 2 grams (g) from previous result two weeks ago. R1's diagnoses included multiple rib fractures and hemothorax. R1's note further indicated after discussion with R1's family, it was determined a transfer to trauma hospital for chest tube (tube inserted into the chest wall to drain plural effusion and treat hemothorax) was not desired and R1 would be comfort care and transition to hospice. R1 expired 10 days after hospitalization.</p> <p>The facility's internal investigation dated 7/2/23, indicated nursing assistant (NA)-B reported walking R1 to the bathroom on 6/30/23 at 10:30 p.m., and R1 stumbled backwards into a radiator and wall outlet. NA-B was able to guide R1's head to avoid head injury but was unable to prevent the fall. Incident was reported to registered nurse (RN)-C. The internal investigation did not indicate the provider was notified at the time of the fall nor a comprehensive assessment or monitoring for injuries was completed.</p> <p>R1's medical record lacked indication a staff member notified R1's provider of incident, or completed continued monitoring or assessment for injury between the time of the incident on 6/30/23, until R1 was sent to hospital for evaluation on 7/2/23.</p> <p>When interviewed on 9/6/23 at 1:58 p.m., family member (FM)-A stated they were notified by NA-A when visiting R1 on 7/1/23 regarding the fall. NA-A told FM-A R1 had fell into the radiator and R1 hadn't been the same with "moving around." FM-A stated R1 appeared to be the same except for being "crabby because he had back and side pain." FM-A stated R1 had been getting Tylenol and ice packs for the back pain. FM-A further</p>	F 684		

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F 684	<p>Continued From page 10</p> <p>stated she had seen some bruising on the front of R1's body, near his chest and was told there was bruising on his back as well. FM-A asked RN-D about the fall, and RN-D didn't know details, but verified R1 fell as there was a nurse note. When visiting R1 on 7/2/22 at aproximatly 12:00 p.m., FM-A stated R1 was sleeping in the recliner by the television in the dining room. FM-A wanted to help R1 with lunch but staff stated R1 just fell asleep after being awake most of the night. FM-A left and returned around 4:30 p.m. to assist R1 with dinner. R1 was still asleep in the recliner in the dining room. FM-A went to wake R1 up and found R1 wouldn't wake to voice. FM-A then notified RN-A something was wrong and requested R1 to be sent to the hospital.</p> <p>When interviewed on 9/6/23 at 3:30 p.m., NA-A stated worked the day of the fall but wasn't in R1's room when the fall happened, but NA-B was and R1's fall was discussed with NA-B and RN-C. NA-A stated the following day, 7/1/23, R1 was "just not the same". R1 had bruising on his back and some on the front and complained of headache and back pain. R1 was also not eating much and had a difficult time transferring. NA-A further stated RN-A was made aware of the changes. On 7/2/23, NA-A stated R1 was worse when coming on shift. R1 was lethargic and not even taking sips of water. NA-A stated FM-A was more vocal with concerns and R1 was sent to the hospital.</p> <p>When interviewed on 9/6/23 at 3:08 p.m., RN-A stated the NAs had informed (RN-A) R1 had a fall sometime prior to their shift on 7/1/23. RN-A stated R1 had complained of a headache, but RN-A had not noted anything unusual with R1 during the evening shift on 7/1/23. On 7/2/523,</p>	F 684		

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F 684	<p>Continued From page 11</p> <p>RN-A stated NA-A stated R1 was more tired than usual, had bruising, and had complaints of rib pain. FM-A also had concerns after they arrived to visit. RN-A stated she completed an assessment, notified the provider, and sent R1 to the hospital for evaluation. RN-A had not assessed R1's bruising and skin as R1 was seated in a common area. RN-A was not aware of any bruising or back pain on 7/1/23, and there was no nurse-to-nurse report of back pain or bruising. RN-A verified there was not any physical monitoring of R1 orders in place during her shifts on 7/1/23 and 7/2/23 and had not completed any assessments or physical monitoring after the fall. RN-A further stated monitoring notes only last for a day or two and thought the monitoring was already completed.</p> <p>When interviewed on 9/6/23 at 3:55 p.m., RN-B stated they cared for R1 on the night shift of 7/1/23 through 10:00 a.m., on 7/2/23. RN-A stated was told R1 fell "a day or two ago" in RN-to-RN report. R1 had hit his back on the radiator and was having some back pain and had been receiving Tylenol. R1 had complained of back pain during the night and had been given Tylenol and was able to go back to sleep. There were no further concerns that night. The following morning R1 was in the dining room for breakfast and had taken his morning medications. R1 had remained in his recliner through the morning napping or watching television. RN-B had reported off to RN-E around 10:00 a.m. RN-B stated there were no orders for post fall monitoring for changes or injuries in place and was not aware of any bruising as RN-B had not completed any cares for R1. RN-B further stated there was nothing indicating R1 required monitoring for bruising and RN-B was</p>	F 684		

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F 684	<p>Continued From page 12 not sure if R1 was on an anticoagulant.</p> <p>When interviewed on 9/7/23 at 9:17 a.m., medical doctor (MD)-A could not find any documentation of R1's fall when reviewing R1's provider and on call documentation. MD-A further stated there was no provider notes or on call documentaion for R1 from 6/27/23 until R1's hospitalization on 7/2/23.</p> <p>When interviewed on 9/7/23 at 9:45 a.m., MD-A stated they expected staff to notify providers right away of residents who fall and were also taking an anticoagulant. Staff were also expected to monitor for bruising, pain, and injury post fall. Furthermore, the medical director expected staff to notify providers if any abnormal assessments or changes after a fall.</p> <p>When interviewed on 9/7/23 at 12:55 p.m., the DON stated initially an internal investigation was started however, was not completed due to a lack in communication. DON had completed further interviews and follow up today after state surveyors entered. DON further stated R1 had a witnessed fall and when the details of the incident are known, a risk analysis wasn't required. DON expected staff to notify the family and provider, on call leader and complete a thorough assessment, including a skin assessment, initiate "post fall order"s after every resident fall to ensure assessments and monitoring for injury were completed.</p> <p>A facility policy titled Fall Prevention and Management revised 2/2021, directed staff to: -notify the provider in a timely manner for any residents noted to be on an anticoagulation as there was significant risk of bleeding.</p>	F 684		

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F 684	<p>Continued From page 13</p> <p>-document the relevant details of the fall. -observe for delayed complications of a fall (72) hours after an observed or suspected fall and will document in the medical record. Documentation will include vital signs, pain, swelling, bruising, decreased mobility, and overall function. -nursing staff will complete and incident review and analysis.</p> <p>The immediate jeopardy that began on 6/30/23, was removed on 9/8/23, when it was verified through staff interviews and document review, the facility reviewed residents who have fallen in the past 14 days were reviewed to ensure provider notification, assessments, and health status monitoring was completed, had educated all licensed nurses and nursing assistants on fall policies and procedures pertaining to monitoring for injuries, and physician notification, before the start of their next shift, and completed a plan for ongoing audits of residents who have fallen.</p>	F 684		

Minnesota Department of Health

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2 000	<p><b>Initial Comments</b></p> <p style="text-align: center;"><b>*****ATTENTION*****</b></p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 9/6/23-9/8/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.</p> <p>The following complaints were reviewed:</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/21/23</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/08/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PARMLY ON THE LAKE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013</b>
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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) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>H53285065C (MN00964070). No licensing orders were issued.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		