STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	28210 Old Towne Road Chisago City, MN 55013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure orders for oxygen use were clarified and documented in the medical record to ensure continuity of care; and failed to ensure physician orders for continuous oxygen use were implemented for 1 of 1 resident (R1) reviewed who used continuous oxygen for comfort. R1's oxygen concentrator machine was not transferred over during a room change and then his portable oxygen tank ran out during the night, causing R1 to go without oxygen for several hours.Findings include: R1's Interagency Referral Form, dated [DATE], identified R1 had multiple medical conditions including obstructive sleep apnea (OSA), high blood pressure, chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular heartbeat), and acute-on-chronic heart failure. The document included R1's discharge orders from the hospital to the care center which included, Oxygen inhalation gas . 2 L/min [liters per minute] at bedtime. Indications: Heart failure. However, R1's Oxygen & Equipment Order Form, dated [DATE], was completed at the care center and signed by health unit coordinator (HUC)-A. This form identified a fax communication sent to the outside oxygen supplier and contained a section labeled, Prescription Information, which marked R1 as having a prescription for 6 L/min continuous oxygen and needing an oxygen concentrator and portable gas tank(s). R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2026, identified R1's administered treatments and medications for the month. This included an order which read, Oxygen 6L via nasal cannula continuously every shift. This had a start date of [DATE], and recorded staff initials for 10 of 11 opportunities as administered. The TAR continued and listed an order which read, Check Portable Oxygen/Stroller every shift and fill if needed. This also had a start date of [DATE], and had staff initials recorded as last completed on [DATE] for the night shift by registered nurse (RN)-B. R1's medical record was reviewed and lacked evidence of a signed physician's order for 6 L/min of oxygen until [DATE] (following death; see below); nor did the record have evidence this discrepancy was identified or clarified to ensure the correct L/min would be administered to R1 despite him having COPD (over-oxygenation in COPD could cause carbon dioxide retention). When interviewed on [DATE] at 12:44 p.m., HUC-A stated orders upon admission were usually sent via email from the director of nursing (DON) and if oxygen was listed, a form was completed and sent to the outside oxygen vendor. HUC-A reviewed R1's medical record and verified they signed R1's Order Form which had 6 L/min written on it. HUC-A then reviewed the discharge orders from the hospital and verified those directed oxygen at 2 L/min. HUC-A stated they thought the 6 L/min directive came from the nurse-to-nurse report but was not sure. HUC-A stated the nurse manager, RN-F, had entered the orders for 6 L/min into the record system (EMR) and verified they were unable to locate a signed physician order for 6 L/min prior to [DATE]. HUC-A stated it was important to ensure oxygen orders were correct and matched for patient safety. R1's MHM (Monarch Healthcare Management) Admission/Initial Data Collection V-9, dated [DATE], identified R1 admitted to the care center from the hospital and had oxygen saturation of 94% on oxygen via nasal cannula. R1 was recorded as having intact cognition, needing extensive assistance with transfers, and having frequent urinary incontinence. The evaluation listed a section labeled, Respiratory Status, which identified R1 had a cough and shortness of breath (SOB), and he used (continued on next page)

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.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen. R1's progress notes, dated [DATE] to [DATE], identified the following information: On [DATE], R1 was stable and had sustained a fall earlier without injury. R1 denied pain and the note added, . is on 6L of oxygen. On [DATE], R1 had hallucinations and was worried people were bugging his telephone. R1 was moved to a different room. On [DATE] at 7:11 a.m., a note identified, Writer called Moment's Hospice . updated Nurse [Name] that patient had expired. A subsequent note identified, After Medicare Nurse spoke with Hospice, writer and she went to [old room] and observed a concentrator in the corner of a closet in the room. Writer later revisited [old room], and the concentrator was sitting outside of the closet, and attached to the electrical outlet. On [DATE] at 9:25 a.m., a note entered by registered nurse (RN)-A identified two night shift nursing assistants (NA) alerted RN-A that R1 was not on oxygen, and that his concentrator was not in the room and the portable tank was empty. RN-A directed another NA to go fill the tank immediately and RN-A responded to R1's room. R1 was seated on the toilet with the PALS (mechanical standing) lift loops attached but he could not be aroused. R1 did not have a heartbeat and was deceased . The two NAs were no longer on shift, and the sequence of events was documented. The director of nursing (DON) and hospice were notified of the death. The note identified the oncoming NA for the morning shift was not notified R1 had been helped to the toilet, and that the aide-to-aide report happened before the two night shift NA alerted RN-A to R1 not having oxygen in his tank. When interviewed on [DATE] at 10:24 a.m., NA-A verified they had worked with R1 during his stay at the care center. NA-A stated the nurse manager or HUC was responsible for clarifying orders for oxygen use upon admission and if a resident used oxygen, it was communicated to the staff using the care plan sheets. NA stated the nurse was allowed to adjust oxygen flow settings, but the NA staff were allowed to change the devices when needed (i.e., change from portable to concentrator). NA-A stated the portable oxygen tanks were filled onsite by the NA staff members usually, and training was reviewed on it annually during a skills fair. NA-A stated it would most likely be me and the more experienced aides who checked the portable oxygen tanks throughout the shift to ensure they still had oxygen available in them as there was not a designated person to do this. NA-A stated they personally tried to check the tanks multiple times a shift, however, they were unsure what other staff did. NA-A stated they were told prior that the night shift was supposed to fill each of the portable tanks for residents; however, that was not happening. NA-A recalled working with R1 on the morning of [DATE] and explained they received report from NA-B who had worked the night shift while NA-C was seen going into R1's room. NA-A was then abruptly asked by RN-A to run and fill [R1's] portable right away. NA-A returned minutes later with the filled tank and saw R1 seated on the toilet and overheard someone say R1 had died. NA-A stated there was not an oxygen concentrator in the room when they observed R1 on the toilet, and the tubing for his cannula was connected to nothing and just lying on the ground. When interviewed on [DATE] at 10:51 a.m., NA-D stated if a resident is in their room, then they should use their oxygen concentrator and not a portable tank as the tank will deplete quicker depending on how many L/min are used. NA-D stated they personally tried to check the portable tanks for their level each time they helped a resident leave their room; however, the overall frequency of when to check it depended on how many L/min the resident used. It was left to each aide to know the L/min being used and how quickly each tank would deplete. NA-D stated when a resident moved rooms, it was everyone's responsibility to ensure equipment got moved to the new room but there was no checklist or documentation completed to track the equipment being moved. On [DATE] at 11:56 a.m., the director of social services (DSS) was interviewed. DSS stated the social worker who oversaw R1's room change was not available; however, explained the social worker typically helped to spearhead the move and ensure equipment is changed over between the rooms. The housekeeping staff was then a second check to ensure items were all moved. If on a weekend, then the floor staff would be responsible for moving the equipment. DSS verified there was no checklist or other documentation to show all equipment was moved to the new room and reiterated it was the staff's responsibility to ensure items got moved. DSS stated they vaguely recalled R1 and were aware of a facility (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation in process about him potentially not getting oxygen because the oxygen equipment had not moved rooms with him. DSS stated they had not yet done any re-education with the social worker who was involved with R1's room change as they were on leave adding, We are going to when she returns. DSS verified there had not been any re-education with the other social worker staff, either, adding, Not at this time. When interviewed on [DATE] at 12:04 p.m., NA-B stated the aides were the ones responsible to fill the portable oxygen tanks, when needed, but nobody from the care center had ever directed or told them how often to check the tanks to ensure oxygen remained. NA-B stated, They never told me anything [about that]. NA-B explained someone would likely know the oxygen had run out as it simply would stop working adding it was between the nurse and aide working to check the tank, but nobody had ever discussed or covered a L/min rate or how to know when a tank would be depleted. NA-B recalled working the night shift into [DATE] and had worked with R1 alongside NA-C who was in training at the time. NA-B stated they complete a safety check every hour during the night on each resident, but this was just a quick peek into the room to ensure their chest was rising. It did not include any check of the oxygen equipment to ensure it was functioning. NA-B stated nobody had ever directed or told them to check oxygen equipment during the night before. Shortly after 6:00 a.m., NA-B stated they sat down with the oncoming NA (NA-A) and gave verbal report. R1 activated his call light and needed to use the bathroom, so NA-C then entered R1's room to assist. NA-B stated NA-C then asked a question about R1's portable oxygen tank, however, NA-B could not recall exactly what was asked. NA-B stated there was only a single portable oxygen tank in the room and no visible oxygen concentrator was present. NA-B made a comment about the lack of concentrator to RN-A who was also present, and RN-A stated they had just moved his room the day prior. NA-B stated nobody from the previous shift (evenings) had mentioned anything about R1's oxygen equipment or where it was located which was abnormal in hindsight. NA-B stated that since the incident with R1 happened, there had been no formal re-education on oxygen use or new direction on how to ensure oxygen doesn't run out while a portable tank is used. There had just been a telephone call from the administrator asking what had happened and some form sent to them via email. NA-B stated they had not yet had a chance to review it. A telephone call was attempted with RN-A on [DATE], however, they were unable to be reached. When interviewed on [DATE] at 12:20 p.m., NA-C stated they had been shown once briefly how to fill an oxygen tank by other staff members but had never been told how often to re-check the tank to ensure it had oxygen still available. NA-C stated, I don't remember ever being told a specific number [when to check], but added they tried to remember to check it at least three times a night. NA-C recalled working with R1 on the night shift into [DATE]. NA-C helped R1 with a bed change around 3:00 a.m. due to incontinence and R1 seemed fine. NA-C had oxygen in place connected to a portable tank, however, NA-C stated they did not check the tank at that time to see its level of remaining oxygen adding, It didn't cross my mind. Shortly after 6:00 a.m., R1 then used his call light and wanted to go to the bathroom. NA-C retrieved a PAL lift and helped R1 to the bathroom when his oxygen tubing became disconnected from the portable tank. That is when NA-C noticed the tank had run out of oxygen and was at zero. NA-C stated they told R1 they were going to fill the tank and to activate the call light when he was done using the bathroom. NA-C then went to the oxygen room and attempted to re-fill the tank but could not get it work, so the other NA then came to help but also couldn't get it to work. By this time, the next shift had arrived so they told them they were going to leave and asked someone else to fill the tank which they said they would do. NA-C recalled checking in on R1 while he was on the toilet but noticed he wasn't looking good so they told someone to make sure the oxygen got filled quickly. Then, later on [DATE], the director of nursing (DON) called them and explained R1 had died that morning. NA-C stated they did not recall ever checking R1's portable oxygen tank throughout the entire night shift until they noticed it was empty when helping him to the toilet adding, It slipped my mind. Since the incident, NA-C stated they were given a survey about oxygen which had a few questions on it; however, they had not gotten any feedback on it yet. During interview on [DATE] 1:18 p.m., RN-B verified they had worked the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orientation checklist lacked any direction on how often to check the tanks when in use to ensure they had remaining oxygen inside. NA-C's Nursing Assistant Facility Orientation Checklist, dated [DATE], identified checkmarks adjacent to areas which were signed off as educated and completed. This identified the same areas of oxygen use as NA-B's checklist, however, again, lacked any direction on how often to check the tanks when in use to ensure they had remaining oxygen inside. A facility policy on oxygen use was requested; however, none was received.