

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Parmly on the Lake LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 Old Towne Road Chisago City, MN 55013	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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's significant change Minimum Data Set (MDS) dated [DATE], indicated R3 was dependent on staff for activities of daily living (ADLs), and 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, 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. 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 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 [DATE], 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 occurThe 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 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 [DATE], 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., 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 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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. 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], indicated R3 was dependent on staff for activities of daily living (ADLs) 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 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 glove 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.		