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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 3G47

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00384

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245286**
2.STATE VENDOR OR MEDICAID NO.
(L2) **964657400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIERZ VILLA, INC**
(L4) **119 FAUST STREET SOUTHEAST**
(L5) **PIERZ, MN** (L6) **56364**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2009**

6. DATE OF SURVEY 09/04/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. The facility is certified for 50 skilled nursing facility beds effective August 28, 2013.

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NEII 9/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS
POSTED 1/6/14 ML 3G47

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5286 December 19, 2013

Ms. Kim Rocheleau, Administrator
Pierz Villa, Inc.
119 Faust Street Southeast
Pierz, Minnesota 56364

Dear Ms. Rocheleau:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 28, 2013, the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Ms. Kim Rocheleau, Administrator
Pierz Villa, Inc.
119 Faust Street Southeast
Pierz, Minnesota 56364

September 11, 2013

RE: Project Number S5286025

Dear Ms. Rocheleau:

On August 6, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 19, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 6, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 28, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 19, 2013, effective August 28, 2013 and therefore remedies outlined in our letter to you dated August 6, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245286	A. Building B. Wing	9/4/2013

Name of Facility	Street Address, City, State, Zip Code
PIERZ VILLA, INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **08/28/2013**	ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **08/01/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/28/2013**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/28/2013**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **08/28/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/cbl	09/11/2013	32209	09/04/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/19/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245286	01 - MAIN BUILDING 01	9/6/2013

Name of Facility	Street Address, City, State, Zip Code
PIERZ VILLA, INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0054	Correction Completed **08/01/2013**	ID Prefix Reg. # **NFPA 101** LSC K0056	Correction Completed **08/28/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/cbl	**Date:** 09/11/2013	**Signature of Surveyor:** 27200	**Date:** 09/04/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 7/16/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3G47

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00384

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245286**

2.STATE VENDOR OR MEDICAID NO.
(L2) **964657400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIERZ VILLA, INC**
(L4) **119 FAUST STREET SOUTHEAST**
(L5) **PIERZ, MN** (L6) **56364**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2009**

6. DATE OF SURVEY **07/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

At the time of the July 19, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NEII — 08/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist 09/09/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5513

August 6, 2013

Ms. Kim Rocheleau, Administrator
Pierz Villa, Inc.
119 Faust Street Southeast
Pierz, Minnesota 56364

RE: Project Number S5286025

Dear Ms. Rocheleau:

On July 19, 2013, a standard survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7365
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 28, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 28, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 October 19, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 January 19, 2014 (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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

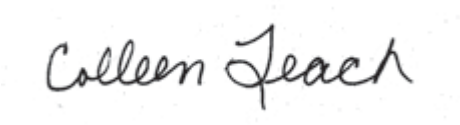
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245286	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ VILLA, INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED AUG 19 2013 MN Dept of Health St.Cloud	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	ok 8.21.13 SC add Dec Sum attached	

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

K Koch 5/15/13 CNA

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.

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	245286	A. BUILDING _____ B. WING _____	07/19/2013

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156	F156 All residents listed in F156 have d/c from facility. However to to assure that all residents whose medicare benefits are ending receive both forms, the Director of Social Services has stapled form 10123 and 10055/denial letter together. The Director of Social Services has also created a binder that will contain all the completed Medicare denial forms to avoid the potential misfiling of a form. The policy and procedure was reviewed and updated. Pierz Villa will audit all residents whose MC benefit ends x3 months to assure both forms are being given. The audits will be shared and discussed with the QA commiittee until resolved. Pierz Villa will be in compliance by 8/28/13.	

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability notices when skilled services ended for 4 of 4 (R29, R38, R41 and R68) residents reviewed in the sample for liability notices. Findings include: R29 was admitted on 3/25/13. R29's record was chosen to review for liability notices. R29's records lacked evidence that any notice, which indicated Medicare benefits were ending, was given. R29 discharged from the facility on 4/3/13. During interview on 7/18/13, at 4:50 p.m. social services (SS)-A, confirmed she was the person responsible to issue the liability notices and stated she could not find any record R29 received the appropriate notices and suggested they had	F 156		

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F 156	Continued From page 3 been misfiled. R38's spouse was given notice of Medicare Non-Coverage, Centers for Medicare and Medicaid Services (CMS) form 10123 on 4/1/13, for benefits that ended on 4/1/13; however, the record lacked evidence if R38 was issued either a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or a denial letter which advises residents if they are no longer eligible for Medicare services and to address liability for payment. R38 remained in the facility after Medicare benefits ended. R41's family was given notice of Medicare Non-Coverage CMS form 10123 on 3/7/13, for benefits that ended on 3/11/13; however, the record lacked evidence if R41's family was issued either a SNFABN or a denial letter which advises residents if they are no longer eligible for Medicare services. R41 discharged from the facility on 3/12/13. R68 was given Notice of Medicare Non-Coverage CMS form 10123 on 5/23/13, for benefits that ended on 5/25/13. R68's record also contained the SNFABN however, it was blank and did not indicate if R68 requested a demand bill. R68 discharged from the facility on 5/29/13. During an interview on 7/19/13, at 10:20 a.m. SS-A stated she would read the Notice of Medicare Non-Coverage CMS form 10123 to residents which informs them of the expedited appeal process and the SNFABN would only be issued if the resident wanted to request a demand bill. During an interview on 7/19/13, at 11:10 a.m. SS-A stated she did not have a form which	F 156		

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F 156	Continued From page 4 showed R68 had requested a claim be submitted for review. SS-A further stated she knew R68 requested a review because R68 called the number on the Notice of Medicare Non-Coverage to request an expedited review. Review of the Medicare Denial Procedure dated 01/08 revealed the social worker would notify resident and/or family member before coverage is denied and completed/signed forms would be filed in the resident's chart.	F 156		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's	F 159		

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F 159	Continued From page 5 behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident funds in excess of $50.00, for residents on Medicaid, or $100.00, for residents on Medicare, were placed in an interest bearing account for 9 of 32 residents (R40, R47, R43, R4, R10, R28, R36, R5, R13) whose personal funds were managed by the facility. Findings include: A review of the "Trust Fund Activity" form printed 7/01/13, revealed residents on Medicaid whose fund accounts were in excess of $50.00 were as follows: R40 with a balance of $58.00, R47 with a balance of $260.60, R43 with a balance of $71.64, R4 with a balance of $100.00. The "Trust	F 159	F159 On 8/1/13 Pierz Villa set up and deposited All resident funds into an interest-bearing account accruing interest at the regular rate of a passbook savings. -The policy and procedure of resident Personal funds was reviewed and updated. -Pierz Villa also updated the admission agreement and resident handbook to reflect this change. -Pierz Villa will audit this by reviewing all deposit slips for the next 3 months to assure that resident funds are being deposited into the interest bearing acct. -Pierz Villa will share this update with the QA committee. -Pierz Villa was in compliance on 8/1/13.	

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F 159	Continued From page 6 Fund Activity" form printed 7/01/13, revealed residents on Medicare whose fund accounts were in excess of $100.00 were as follows: R10 with a balance of $163.67, R28 with a balance of $113.78, R36 and R5 who shared an account with a balance of $440.88 and R13 with a balance of $92.45. During an interview on 7/17/13, at 1:46 p.m., business manager (BM)-A indicated resident personal fund accounts were pooled into one account which was not an interest bearing account. BM-A stated at one time the account did accrue interest, but thought the account changed back in 2000. Review of the Resident Personal Funds policy (undated) revealed families and residents would be explained that accounts with greater than $100.00 in it would be in a non-interest bearing account upon admission.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		

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F 225	Continued From page 7 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure allegations of abuse/neglect and injuries of unknown origin were reported to the State agency (SA) for 2 of 16 (R61 and R12) records reviewed. In addition, the facility failed to thoroughly investigate abuse/neglect allegations and injuries of unknown origin for 2 of 16 (R61, R12) records reviewed. Findings include: An interview with R61 on 7/17/13, at 8:44 a.m. revealed that on 6/12/13, nursing assistant (NA) -A took a bedpan out from underneath R61 and	F 225	F225 On 7/18/13 Pierz Villa completed a more thorough investigation of R61's incident. we interviewed the resident again, who continued to express satisfaction with care and that she thought this issue was resolved. Pierz Villa placed the AP on leave, interviewed all residents and any staff that could have been involved with the care R61 received. -On 7/18/13 Pierz Villa submitted a report to OHFC and CEP along with the internal investigative report. OHFC's findings were returned to facility on 7/30/13 stating the incident was unsubstantiated. R61 has since discharged the facility. -R12's incident log did note that her bruise was not reported. This was based on the nurse note findings that she had a fall out of bed on 7/30/12, 4 days prior to the finding of the bruise. However, on 8/12/13 to comply with MDH findings, Pierz Villa reported the incident to OHFC and CEP. Resident has since expired. -In order to assure that all unknown injuries that are unexplainable and are suspicious of abuse and any negligent care is thoroughly investigated and reported to the SA timely Pierz Villa has reviewed and updated the vulnerable Adult Policy and procedures. -All staff were educated on 8/8/13 on the policies and educated on reporting guidelines. -All staff were educated on the revised	

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F 225	Continued From page 8 pulled up her clothes. R61 felt wet and requested to have the wet linens and clothes changed. NA-A argued with R61 and indicated that R61 was not wet and neither were the linens. NA-A then left R61's room and left R61 lay on the wet bed linen after the bed pan had spilled. R61 called for assistance and two staff assisted to changed R61's wet clothing and bedding. R61 stated that she, "reported the incident to the social worker." R61's Minimum Data Set (MDS) dated 6/12/13, indicated R61's cognition was intact. R61's care plan dated 5/30/13, directed two-three staff to assist R61 with transfers and a total body mechanical lift. A Resident Need Protocol dated 5/30/13, indicated that R61 needed 2 staff for toileting. An interview on 7/18/13, at 8:52 a.m. with social worker (SW)-A identified R61 had told SW-A that NA-A had spilled some of the contents of the bedpan on the bed. R61 had told NA-A that the bed was wet. NA-A argued with R61 the bedding was not wet and left R61's room. R61 called for more assistance and two other staff assisted to change the wet clothing and linen. SW-A indicated R61 could refuse assistance from NA-A at any time. A second interview at 2:23 p.m. with SW-A indicated a report to the State agency (SA) was not completed nor was the incident documented on a facility Resident Incident Report. SW-A stated that no other residents or staff was interviewed related to this incident. An interview on 7/18/13, at 11:52 a.m. with the administrator who stated, "We are a small facility and we deal with these issues immediately." The administrator indicated the facility policy and	F 225	complaint form and how to use it at their respective department meetings. -The director of Social Services has also updated log tracking book for all reports that are submitted to the SA. -An Investigation form has been added to the resident incident/accident report form in which nurses complete. Education on This form will be provided on 8/27/13 to all -nursing staff. -To assure that any reports made to the SA are timely, Pierz Villa will audit all reports monthly x3 months or until resolved. Pierz Villa will also audit to see that there was a thorough investigation completed. -All tracking logs and audits will continue to be shared and discussed with the QA committee . Pierz Villa will be in compliance by 8/28/13.	

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F 225	Continued From page 9 procedures were not followed for this incident to include a thorough investigation. The administrator also identified the SA was not notified of the incident. R12's MDS dated 6/15/13, indicated that R12 required the assist of two staff for transfers. R12's cognition was severely impaired. R12's progress notes dated 8/3/12, indicated a staff noted a 5 centimeter (cm) bruise on R12's right buttock. The facility's incident log lacked information if the incident was reported to the SA and if there was a thorough investigation. In addition there was no documentation related to R12's right buttock bruise in R12's medical record to indicate if the information was reported to the SA and if there was a thorough investigation. The facility was unable to provide a Resident Incident Report related to the bruise on R12's right buttock. The facility was unable to provide information if this injury of unknown origin was reported to the SA and thoroughly investigated. An interview on 7/18/13, at 9:24 a.m. with the director of nurses (DON) indicated the facility shreds all Resident Incident Reports after three months. The facility was unable to provide information to indicate if the bruises for R12 were reported to the SA and any information in regards to an investigation. The facility policy entitled Abuse/Neglect and Misappropriation Policy (dated 8/12), indicated that a Resident Incident Report will be filed out on all alleged incidents of Abuse/Neglect. Any alleged abuse would be called to the appropriate SA. The policy revealed that immediately means as soon as possible but ought not exceed 24 hours upon receiving the information of the	F 225		

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F 225	Continued From page 10 alleged abuse, call the appropriate agencies and administrator immediately. The facility policy entitled Abuse, Neglect and Misappropriation of Property-Vulnerable Adult and Neglect Prevention Plan (dated 8/12) identified, "DON, Director of Social Services and the Administrator will be responsible for ensuring the incident has been analyzed to determine if changes to facility's policies and procedures are needed to avoid further occurrences."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure the abuse prohibition policies and procedures which required immediate notification to the state agency and a thorough investigation of any alleged abuse, neglect, injuries of unknown origin were implemented for 2 of 16 residents (R61, R12) records reviewed. Findings include: The facility policy entitled Abuse/Neglect and Misappropriation Policy (dated 8/12), indicated that a Resident Incident Report will be filed out on all alleged incidents of Abuse/Neglect. Any alleged abuse would be called to the appropriate	F 226		

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F 226	Continued From page 11 SA. The policy revealed that immediately means as soon as possible but ought not exceed 24 hours upon receiving the information of the alleged abuse, call the appropriate agencies and administrator immediately. The facility policy entitled Abuse, Neglect and Misappropriation of Property-Vulnerable Adult and Neglect Prevention Plan (dated 8/12) identified the "DON [director of nursing], Director of Social Services and the Administrator will be responsible for ensuring the incident has been analyzed to determine if changes to facility's policies and procedures are needed to avoid further occurrences." R61's Minimum Data Set (MDS) dated 6/12/13, indicated that R61's cognition was intact. R61's care plan dated 5/30/13, directed two-three staff to assist R61 with transfers and a total body mechanical lift. A Resident Need Protocol dated 5/30/13, indicated that R61 needed 2 staff for toileting. An interview with R61 on 7/17/13, at 8:44 a.m. revealed that nursing assistant (NA) A took a bedpan out from underneath R61 and pulled up her clothes. R61 felt wet and requested to have the wet linens and clothes changed. NA-A argued that R61 was not wet and neither were the linens. NA-A then left R61's room and left R61 lay on the wet bed linen after the bed pan had spilled. R61 called for assistance from two other staff who changed R61's wet clothing and bedding. R61 stated that she "reported the incident to the social worker." An interview on 7/18/13, at 8:52 a.m. with social worker (SW)-A indicated R61 had stated that NA-A had spilled some of the contents of the bedpan on the bed. R61 had told NA-A that the	F 226	F226 On 7/18/13 Pierz Villa completed a more thorough investigation of R61's incident. we interviewed the resident again, who continued to express satisfaction with care and that she thought this issue was resolved. Pierz Villa placed the AP on leave, interviewed all residents and any staff that could have been involved with the care R61 received. -On 7/18/13 Pierz Villa submitted a report to OHFC and CEP along with the internal investigative report. OHFC's findings were returned to facility on 7/30/13 stating the incident was unsubstantiated. R61 has since discharged the facility. -R12's incident log did note that her bruise was not reported. This was based on the nurse note findings that she had a fall out of bed on 7/30/12, 4 days prior to the finding of the bruise. However, on 8/12/13 to comply with MDH findings, Pierz Villa reported the incident to OHFC and CEP. Resident has since expired. -In order to assure that all unknown injuries that are unexplainable and are suspicious of abuse and any negligent care is thoroughly investigated and reported to the SA timely Pierz Villa has reviewed and updated the vulnerable Adult Policy and procedures. -All staff were educated on 8/8/13 on the policies and educated on reporting guidelines. -All staff were educated on the revised	

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F 226	Continued From page 12 bedding was not wet and left R61's room. R61 called for more assistance and two other staff assisted to change the wet clothing and linen. SW-A stated that R61 could refuse assistance from NA-A at any time. A second interview at 2:23 p.m. with SW-A indicated that a report to the SA was not completed nor was the incident documented on a facility Resident Incident Report. The SW stated that no other residents or staff was interviewed related to this incident. An interview on 7/18/13, at 11:52 a.m. with the administrator who stated the NA-A was educated on the appropriate care for residents, shown the policies, and a written warning was given. The administrator stated "we are a small facility and we deal with these issues immediately." The administrator stated the facility policy and procedures were not followed for this incident. The administrator stated that the SA was not notified of the incident. R12' cognition was severely impaired. R12's progress notes dated 8/3/12, indicated a staff noted a 5 centimeter (cm) bruise on R12's right buttock. The facility's incident log lacked information if the incident was reported to the SA and if there was a thorough investigation. In addition there was no documentation related to R12's right buttock bruise in R12's medical record to indicate if the information was reported to the SA and if there was a thorough investigation. The facility was unable to provide a Resident Incident Report related to the bruise on R12's right buttock. The facility was unable to provide information if this injury of unknown origin was reported to the SA and thoroughly investigated.	F 226	complaint form and how to use it at their respective department meetings. -The director of Social Services has also updated log tracking book for all reports that are submitted to the SA. -An investigation form has been added to the resident incident/accident report form in which nurses complete. Education on This form will be provided on 8/27/13 to all -nursing staff. -To assure that any reports made to the SA are timely, Pierz Villa will audit all reports monthly x3 months or until resolved. Pierz Villa will also audit to see that there was a thorough investigation completed. -All tracking logs and audits will continue to be shared and discussed with the QA committee . Pierz Villa will be in compliance by 8/28/13.	
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 F 278 SS=D	Continued From page 13 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected each resident's status for 3 of 5 (R25, R19 and R21) reviewed.	F 278 F 278	F278 To assure that MDS data currently reflects R25, R19 and R21's dental status, Modifications were completed on 8/12 and 8/13/13. These residents care plans were Also reviewed and updated to reflect Their current section 'L' MDS assessment. -To assure that all other residents current MDS assessment reflects their dental status, Pierz Villa will review residents most recently completed MDS, Section 'L'. -Pierz Villa also provided education to the MDS coordinator on the Importance of coding and assessment accuracy. -Pierz Villa will audit R25, R19 and R21's Next assessment section 'L' and 4 other resident's MDS section 'L' weekly x1 month, then 4 residents MDS's every other week for 2 months or until resolved. These audits will be shared and discussed with the QA committee until resolved. Pierz Villa will be in compliance by 8/28/13.	

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F 278	Continued From page 14 Findings include: The facility's quarterly assessment MDS dated 5/2/13, did not accurately reflect R25's dental status. R25's quarterly MDS dated 5/2/13, Section L Oral/Dental Status directed staff to check boxes to indicate broken or loosely fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, mouth or facial pain, and discomfort or difficulty with chewing. The assessment was completed with no check marks. R25's physician progress notes, dated 2/19/13, included "She has been having some tooth/gum issues. She apparently has a protrubulence in her lower gumline that is causing her pain when she wears her dentures." On 4/16/13, notes included "She continues to have dental pain since she has had her teeth pulled. This is her biggest frustration." R25's dietary progress notes, dated 4/30/13, identified R25 continued with a mechanically soft diet due to "her dentures not fitting well...She has c/o [complained of] these moving when she eats and creating sores on her bottom gums and therefore is not wearing these." R25's plan of care, dated 10/29/11, updated 2/1/13, indicated under nutrition "Edentulous [with] one tooth in mouth. Now preferring all meats grnd [ground]." During an interview on 7/18/13, at 3:15 p.m., RN-A, who was responsible for completion of MDS assessments, reported the MDS was not	F 278		

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F 278	Continued From page 15 coded correctly. "I just missed it." R19's admission assessment MDS dated 6/7/13, did not accurately reflect R19's dental status. R19's MDS dated 6/7/13, Section L Oral/Dental Status directed staff to check boxes indicating broken or loosely fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, mouth or facial pain, and discomfort or difficulty with chewing. The assessment indicated "no natural teeth or tooth fragments." No other areas were checked. Review of R19's care area assessment (CAA) dated 6/7/13, revealed he complained of loose bottom dentures. Review of R19's plan of care dated 6/21/13, included "wears upper and lower dentures. Is edentulous. States has 'loose' dentures." During an interview on 7/17/13, at 12:03 p.m., RN-A reported the information was included in the CAA's and the care plan was written subsequent to that. "Yeah, I should have checked for loose dentures. Human error. Yes, I coded it wrong." R21's admission MDS dated 4/29/13, did not accurately reflect R21's dental status. R21's MDS dated 4/29/13, Section L Oral/Dental Status directed staff to check boxes indicating dentures poorly fitting or broke, no natural teeth or fragment, abnormal mouth tissue, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, mouth or facial pain. The assessment was completed with no check marks.	F 278		

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F 278	Continued From page 16 R21's Plan of Care-Speech Therapy dated 4/23/13, indicated that R21's teeth are in poor condition. R21's Nutritional Assessment dated 4/29/13, revealed missing teeth, teeth are in poor condition. R21's Resident Care Plan dated 5/8/13, indicated that R21's teeth were in good repair. An interview on 7/18/13, at 12:55 p.m. with RN-A revealed that the speech therapy note and nutritional note were not looked at for the MDS assessment by RN-A and therefore the MDS was coded incorrectly.	F 278		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dining assistance in a sanitary manner related to bare hand contact with ready to eat foods, for 1 of 5 residents (R9) who required staff assistance. Findings include:	F 371		

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F 371	Continued From page 17 During an observation of the evening meal on 7/15/13, at 5:49 p.m., nursing assistant (NA)-D was assisted R9 to eat. With bare hands, NA-D touched her own hair, her own clothing, the table, and the back of R9's chair. Without washing her hands or donning gloves, NA-D picked up the grilled cheese sandwich on R9's plate, and handed it to her. During an interview on 7/18/13, at 8:30 a.m., dietary manager (DM) stated staff should never touch food with their bare hands. During an interview on 7/18/13, at 11:10 a.m., NA-D stated if she assisted a resident to eat and she needed to hand them a food item, she would "pick it up and give it to them." When asked if it was okay to touch the food with bare hands, she stated, "Yes, I've never been taught that I can't do that." NA-D also stated, "No one puts on gloves... I didn't know you couldn't touch the food. No one has ever told me that I can't do that." Review of the facility's Meal Service in the Dining Room policy dated 5/02, noted, " Foods needing to be cut, jellied etc, are done so with a knife and a fork. Deli tissues are available at the serving counter also. Hand to food touching is not allowed during assisting. " Review of the facility's Hand Washing and Glove Use policy, undated, specifies "Gloves must be worn when touching any ready-to-eat food."	F 371 F371	In order to assure that R9 and all resident's food is handled in a sanitary manner Pierz Villa reviewed and updated the policy Meal Service in the Dining Room. -Nursing staff was educated on 7/23/13 via a communication note. All staff were educated on the policy on 8/8/13. -All new employees will meet with the CDM upon hire and review the policy. -Pierz Villa will audit 3 meals each week for one month. Then 2 meals each week for month and then 1 meal each week for 1 month or until resolved. Pierz Villa will share and discuss the audit results with the Quality Assurance committee until the issue is resolved. -Pierz Villa will be in compliance by 8/28/13.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 18 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive infection	F 441	F441 Plerz has an infection control program In place to minimize the transmission Of disease and infection, however we Will implement the following measures: -A resident infection control report will be Completed by the RN or LPN each time a Resident displays signs and symptoms of An infection or starts on an antibiotic. This Form will collect the information needed to Identify and track potential outbreaks or Infection control issues. The completed Form will be routed to the infection control Nurse who will track and trend the data Collected and put protocols in place as Needed. -Plerz Villa has implemented an employee Report form. This form will be filled Out by each employee for any absence due To illness. This form will collect the data For the infection control nurse to analyze Employee signs and symptoms compared To resident signs and symptoms of Infection and allow infection control nurse To put protocols into place as needed. -A monthly summary will be completed by The infection control nurse to analyze data Collected. This summary will identify Any trends, if any, among residents and/or Staff. This information will also be reviewed Monthly with the DON for any follow-up That may be necessary.	

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F 441	Continued From page 19 control program was in place to minimize the transmission of disease and infection, related to the following: The facility failed to summarize the statistical analysis completed by comparing the data to previous months, to local/ national trends and to employee signs/ symptoms in order to provide meaning to the results, allowing for appropriate, applicable corrective actions; The facility's surveillance system lacked collaboration of data between registered nurse case managers, the director of nursing and the infection control coordinator to ensure early identification of trends, including signs/ symptoms of resident infections prior to antibiotic use and signs/ symptoms of employee infections; The facility's surveillance system lacked consistent identification of locations within the facility where infections had occurred. This had the potential to effect all 40 of 40 residents who resided in the facility. Findings include: Review of the facility's infection control logs from 7/12 through 6/13 revealed the following: - Monthly infection rates per 1,000 resident days were 6.4%, 8.0%, 8.3%, 2.9, 8.2%, 6.15%, 7.7%, 2.7%, 10.3%, 2.5%, 10.3%, 11.2% respectively. No explanation or written analysis was noted for the varying infection rates within the facility. -Logs lacked evidence of the data collected as having been compared to the data from previous months. -Logs lacked evidence of employee signs/ symptoms of infection having been compared to resident signs/ symptoms of infection. -No data for signs/ symptoms of infections was collected for residents who did not receive antibiotics.	F 441	-To ensure that protocols are being Followed Pierz Villa will audit that the data Is being collected and analyzed on a Monthly basis. -These audits and data collected will be Shared and reviewed with the QA Committee on an ongoing basis. -Pierz Villa will be in compliance by 8/28/13.	

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F 441	Continued From page 20 -Infection data was separated between the North and South wings, with resident room numbers identified through 12/12. From 1/13 through 6/13 resident room numbers were no longer identified. During an interview on 7/18/13, at 3:55 p.m. with the infection control registered nurse (RN)-A it was reported that once monthly, she tallied infection types, organisms, antibiotics used, the number of infections present on admission verses nosocomial infections, the number of infections resolved verses unresolved and divided the data between the North and South wings of the facility. She also determined the monthly infection rate per resident hours. Though the data was collected and tallied, RN-A verified there was no further, additional analysis of the data. RN-A verified that she was not familiar with national/ local trends with regards to resident infection rates and was unable to discern whether the facility had a higher rate of infection, which might have prompted a more detailed analysis to determine cause and whether more involved corrective action was appropriate. She verified the facility's infection rates seemed to vary greatly and was unable to provide explanation for the variations. RN-A reported that the director of nursing (DON) noted employee signs/ symptoms of infection on a call-in slip if the employee offered this information. RN-A reported that within approximately two weeks of an employee having called in, she received the employee call-in slips, which she then filed away. RN-A confirmed that she did not compare the employee illness information with resident infections within the facility to identify potential breaks in infection control procedures. RN-A reported that one employee infection in the past year was identified as having been contracted by some of the	F 441		

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F 441	Continued From page 21 residents because the employee offered information that she had developed a specific infection and it was then discovered that some of the residents had developed the same infection. RN-A reported that the facility's response to this discovery and other resident infection patterns identified was to inform the DON and RN case managers. Upon inquiry as to her process for gathering infection surveillance data, RN-A explained that all new physician orders ran through her and whenever an antibiotic had been ordered, she added the resident to the facility's tracking sheet. RN-A verified it was not the facility's process to track or trend signs/ symptoms of resident infections prior to an order for antibiotics. She explained that the facility's RN case managers typically observed residents for signs/ symptoms and documented the signs/ symptoms in the individual resident's medical record. She reported that non-pharmacological interventions were then added to the residents written plan of care. RN-A reported that the RN case managers then informed the physician when necessary, so a culture could be completed and an antibiotic ordered. It was only at this point (after the antibiotic was ordered) that tracking, trending and data collection of resident infections began. RN-A verified that she did not consistently identify resident room numbers in her logs. She reported that given the small size of the facility, she was able to recall by memory where resident rooms were located. During an interview on 7/19/13, at 9:44 a.m. the DON verified the facility did not complete formal tracking/ trending of resident infection signs/ symptoms, such as fever or vomiting. The DON reported that when a resident showed these signs/ symptoms, it was documented in the	F 441		

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F 441	Continued From page 22 progress notes of that individual resident's medical record. The DON added, with "such a small, 50-bed facility," she was aware of residents who showed signs/ symptoms of infections and she noticed when residents exhibited similar symptoms. The DON explained that when similar symptoms were identified, she provided staff education as appropriate. The DON verified the facility did not complete formal trending or comparison of employee symptoms/ infections with resident symptoms/ infections. The DON added, "Again, with such a small facility... I don't have very many call-ins... I know when there is a bug going around..." Review of the facility's Infection Control Program policy revised 1/12, read, "All personnel will be responsible to report signs and symptoms of infections from themselves and from the residents to the appropriate staff person." Review of the facility's Surveillance of Infectious Disease policy revised 1/12, revealed nursing staff were responsible to notify RN case managers when residents exhibited any of the following: Temperature of 100 degrees Fahrenheit (F) or greater, three or more liquid stools in a 24 hour period, inflammation or pus at a skin site and transfers to the hospital because of a communicable disease. The policy added, "The Infection Control Coordinator must collect the data to remain aware of trends or of an increase in prevalence of infectious conditions." Review of the facility's Surveillance for Nosocomial Infections policy revised 1/12, included the following data gathering tools that could have been used to identify indicators of nosocomial infections: Staff interviews,	F 441		

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F 441	Continued From page 23 pharmacy records, laboratory reports, chart reviews, new order board and admission assessments. The policy detailed that laboratory reports were to be reviewed for identification of the organism cultured, identification of sensitivities to current medications, identification of resistance to specific medications, assessment for patterns of organisms for a specific resident or for the facility and assessment for patterns of resistance to specific medications.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident call systems were applied in a functional manner, with the potential to effect 2 of 30 resident bathrooms (R34 and R27) observed and 2 of 2 residents (R53 and R47) who utilized a women's restroom located next to a common area that was used for activities. Findings include: R34 had diagnoses that included stroke and history of falls. The annual Minimum Data Set (MDS) dated 5/17/13, revealed R34 was cognitively intact and required extensive assistance for most activities	F 463	F463 R34, R27 and the women's bathroom call cords were untied to hang freely upon identification on 7/18/13. -Education was provided on 7/18/13 to all Nursing staff on 7/18/13 via Communication notes. All other staff were Educated at their respective department Meetings. -To assure that bathroom call cords are not Tied to assistive devices Pierz Villa will Audit R34, R27, women's restroom and 5 other random rooms 2x week for the 1st Month. Then once a week for 1 month and Then every other week for one month or Until resolved. These audits will be shared And discussed with the QA committee until Resolved. -Pierz Villa will be in compliance by 8/28/13	

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	245286	A. BUILDING _____ B. WING _____	07/19/2013

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F 463	Continued From page 24 of daily living, including toileting and transfers. The MDS also indicated R34 required a walker or a wheelchair for mobility and was frequently incontinent of bladder and always continent of bowel. The MDS revealed R34 had experienced two falls with minor injury since the prior quarterly assessment. During an observation on 7/15/13, at 6:51 p.m. R34's bathroom call light cord was noted to be tied around the grab bar next to the toilet. When pulled from the bottom of the cord, the call light did not engage as it simply tugged at the knot that was tied around the grab bar. When the call light was pulled from above the grab bar, it did engage. The height of the grab bar was approximately three feet from the floor, potentially leaving the call light out of reach if R34 had fallen to the floor. R27 had diagnoses that included visual impairment, history of vasovagel syncope (sudden, brief loss of consciousness) and history of falls. The quarterly MDS dated 5/24/13, identified R27 as cognitively intact, independent with activities of daily living and always continent of bowel and bladder. The MDS also identified R27 required the use of a walker for mobility and had a visual impairment (sees large print but not regular print in newspapers/books). The MDS indicated R27 had experienced one fall with minor injury since the prior quarterly assessment. During an observation on 7/16/13, at 9:26 a.m. R27's bathroom call light cord was noted to be tied around the grab bar next to the toilet. When pulled from the bottom of the cord, the call light	F 463		

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F 463	Continued From page 25 did not engage as it simply tugged at the knot that was tied around the grab bar. When the call light was pulled from above the grab bar, it did engage. The height of the grab bar was approximately three feet from the floor, potentially leaving the call light out of reach if R27 had fallen to the floor. R53 had diagnoses that included dementia. The quarterly MDS dated 4/26/13, revealed R53 had a severe cognitive impairment, required a walker for mobility, was independent with most activities of daily living, including transfers, but required extensive assistance with toileting. The MDS identified R53 as occasionally incontinent of bladder and always continent of bowel. The MDS indicated R53 had experienced one fall with no injury since the prior quarterly assessment. R47 had diagnoses that included dementia. The annual MDS dated 6/12/13, identified R47 was moderately cognitively impaired and was independent with most activities of daily living, including transfers and toilet use. The MDS indicated R47 required the use of a walker or wheelchair for mobility, was occasionally incontinent of bladder and was always continent of bowel. The MDS indicated R47 had not experienced any falls since the prior quarterly assessment. During a random observation on 7/17/13, at 2:00 p.m. the call light cord in the women's restroom (located next to a common area that was used for activities) was noted to be tied around the grab bar next to the toilet. When pulled from the bottom of the cord, the call light did not engage as it simply tugged at the knot that was tied around the grab bar. When the call light was	F 463		

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F 463	Continued From page 26 pulled from above the grab bar, it did engage. The height of the grab bar was approximately three feet from the floor, potentially leaving the call light out of reach if residents who utilized the bathroom had fallen to the floor. During the environmental tour with the facility administrator and maintenance director on 7/18/13, at 10:30 a.m., the call light cords in R34's bathroom, R27's bathroom and the common area women's bathroom were again noted to be tied around the grab bars. The administrator and the maintenance director verified these findings and confirmed that if a resident had tried to pull the cord below the knot that was tied around the grab bar, the call light would not have engaged. The administrator verified that call lights were not to be tied to the grab bars. She also verified that the common area women's bathroom was used by some of the residents during activities, including BINGO. On 7/19/13, at 11:15 a.m. the administrator reported that R53 and R47 were the only residents who may have utilized the restroom during BINGO activities. Review of the facility's Call Lights policy dated 8/00, instructed that all staff were responsible to ensure call lights were placed within reach before leaving a room.	F 463		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping and maintenance needs were identified and addressed. This had the potential to effect all 40 of 40 residents who resided in the facility. Findings include: During initial tour observations on 7/15/13, at approximately 12:30 p.m. the following environmental concerns were noted: - Several spiders and dead bugs were noted on the window sills of the facility's activity room. -Dust build up on fans in the activity room and the North nurse's station. -Damaged weather stripping on the patio door. -Loose trim above the radiator in the main dining room. -Water damaged ceiling tiles in the South day room -Missing vent cover on the refrigerator in the North kitchenette. During a dining observation on 7/15/13, at 5:37 p.m. food debris was noted on the window of the West end of the dining room where one resident was observed to dine, facing the window. During a random observation on 7/17/13, at 12:50 p.m. the North wing kitchenette refrigerator was noted to be missing the vent cover. The tiled flooring around the bottom of the refrigerator was noted as worn/ chipped. At the time of observation, licensed practical nurse (LPN)-A verified the kitchenette area was utilized by both residents and families.	F 465	F465 In reference to this deficiency it shall be known that Pierz Villa does not agree with many aspects it. However Pierz Villa will remedy this deficiency. -The west window of the dining room had no apparent food or oral secretions noted by administrator or maintenance director during facility tour. This window did have a resident choosing to eat facing this window, however after each meal the dietary staff cleaned this window. This was a unique circumstance and the resident was discharged from facility on 7/20/13. -The north kitchenette refrigerator vent cover was found and replaced on 8/12/13. tiles under and around refrigerator were inspected and no findings of worn or chipped flooring was noted. To assure that the north and south fridge's vent	

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F 465	Continued From page 28 During a random observation on 7/18/13, at 10:00 a.m. a six by six inch area of water damage was noted on a ceiling tile in the North wing. The area was discolored from a speckled white to a yellow-tan color with the outer edges defined with a darker, brown color. During the environmental tour with the facility administrator and maintenance director on 7/18/13, at 10:30 a.m., the following maintenance/ housekeeping concerns were noted: Dust build up was noted on fans in the North nurse's station and in the soiled laundry room. The blade edges on both fans were lined with a dark gray film and the outer cover of the fans had a dusty film. The fan in the soiled laundry room was noted to be facing into the laundry area, with the door between the two rooms propped open. The maintenance director reported that dusting fans in the facility was on a monthly cleaning schedule. He reported that if the fans required more frequent cleaning, the facility employee who noticed the need was responsible for filling out a maintenance request slip. The maintenance director reported that no requests indicating the fans needed to be cleaned had been submitted. Oral secretions and/or light food debris was noted on the window of the west end of the dining room. The administrator reported that windows in common areas, including dining room windows, were cleaned in the Spring and Fall. The administrator verified that she was aware that a resident routinely faced that window during meals. The maintenance director verified the window had not been identified as needing to be	F 465	covers remain intact, Pierz Villa will audit this 1x month for 3 months or until resolved. Pierz Villa will educate all sStaff on use of maintenance request slips at respective department meetings. Pierz Villa will be in compliance on 8/28/13. -The north fan and fan in laundry room was cleaned on 7/23/13 by the maintenance supervisor. In order to assure that all fans used by facility are free of debris Pierz Villa reviewed the policy relating to cleaning of fans and updated it. Pierz Villa has changed the policy to reflect biweekly cleaning if needed vs.monthly. Pierz Villa has added this check to safety checklists that are completed on a quarterly basis. Pierz Villa will educate all staff on use of maintenance request slips. Pierz Villa audit all facility fans for cleanliness every other week x3 months or until resolved. The audits will be shared with the QA committee until resolved. Pierz Villa will be in compliance by 8/28/13. -The south area sunroom water damaged area was fixed on the roof quite sometime ago, prior to MDH entering the facility. The spot on the ceiling was painted on 7/23/13 by the maintenance director. Maintenance director looked throughout facilityfor other water damaged areas and fixed or replaced tiles as needed. The ceiling was visually inspected for growth of mold, none has been found. Pierz Villa will be fixing the roof and then the office ceilings will be fixed the week of August 12th.	

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F 465	Continued From page 29 cleaned, no maintenance/ housekeeping request had been submitted. Water damaged ceiling tiles were noted in the South day room. The area in the South day room was approximately one foot by one foot. The area was discolored from white speckled tile to a yellow/ tan color, with brown, defined edges. The administrator verified the facility had suffered water damage due to excessive rainfall a couple of months prior. She reported that most of the water damage in the facility occurred in the center, where the water on the roof had pooled. The administrator indicated further water damage occurred in the administration/ business offices of the facility. The administrator reported that she had been working with the owners of the facility to remedy the roof leaks; however, she denied any efforts had been made to limit the development of mold in relation to the water damage that had occurred. The administrator indicated that her priority focus had been to remedy the leaks in the roof. The maintenance director reported that he had patched up the water damaged tile in the South day room, but it still needed to be painted. The maintenance director verified no efforts had been made to limit the development of mold in relation to the water damage. Weather stripping was noted to be missing from the lower half of the patio door, which left an opening of approximately a quarter inch in width. The patio area outside the door was visible through the opening. The maintenance director verified the missing weather stripping had not been previously identified by the facility. Trim above the radiator in the main dining room was unaffixed from the wall. The portion of trim	F 465	-The weather stripping noted missing on the patio door was replaced on 7/19/13. the maintenance director inspected all other entry doors and found no other doors needing replacement. To assure that weather-stripping does not go missing Pierz Villa has added this check to quarterly safety checklists. Pierz Villa will educate all staff on use of maintenance request slips at their respective department meetings. Pierz Villa will be in compliance by 8/28/13. this finding will be shared and reviewed With the QA committee. -The trim above the radiator in the dining room was wire conduit that was fastened with double faced tape that was beginning to pull away from the wall. This strip was affixed to the wall on 7/23/13 by the maintenance director screwing it to the wall. Pierz Villa will educate all staff on use of maintenance request slips at their respective department meetings. Pierz Villa will be in compliance by 8/28/13. This finding will be shared and reviewed with the QA committee.	

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F 465	Continued From page 30 that was loose and pulled away from the wall was approximately three feet in length. The administrator and maintenance director verified the trim had not been previously identified by the facility. The refrigerator vent cover in the North wing kitchenette was missing. The maintenance director verified he had not previously identified this maintenance need. On 7/18/13, at 10:35 a.m. the maintenance director reported that the facility completed monthly environmental audits for safety and maintenance needs. He added, maintenance request slips were also available at each nurse's station for any staff to report maintenance/ housekeeping needs. The maintenance director reported that he picked up request slips from each of the nurse's stations each morning. The maintenance director verified the facility had not previously identified any of the concerns noted above and no request slips had been submitted regarding these concerns. Review of the facility's Maintenance Slip Policy revised 7/13, revealed, "Maintenance requisition forms are available at all work areas of the facility... All employees are expected to complete the form as needed. Complete the form as soon as possible if equipment is not working properly, or if you question the functioning." The policy indicated that prompt assessment/ repair of malfunctioning equipment would be provided.	F 465	-The observation noted by MDH of dead bugs and spiders was not observed by Administrator or Maintenance Director during the tour. However to remedy the identified concern, Pierz Villa housekeeping department policy was reviewed at their department meeting on 8/14/13. housekeeping will be cleaning out all windowsills identified as needing to be cleaned, including the activity room. Pierz Villa also added this check to the quarterly safety checklists. Pierz Villa will audit 5 windowsills and the activity room sills on a weekly basis for one month, and then will decrease the audits to every other week for 2 months or until resolved. Pierz Villa will be in compliance by 8/28/13. These findings will shared and reviewed with the QA committee.	
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		

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F 469	Continued From page 31 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an effective pest control program was in place, related to pests noted in resident rooms and common areas throughout the facility. This had the potential to effect all 40 of 40 residents who resided in the facility. Findings include: During the initial tour on 7/15/13, at 12:30 p.m. several spiders and dead bugs were noted on the window sills of the facility's activity room. In the facility's main dining room, R20 was noted to have a fly swatter that rested on her lap while she ate. During an observation of the evening meal on 7/15/13, at approximately 5:30 p.m. R20 was again noted to have a fly swatter that rested on her lap while she ate in the main dining room. During an observation on 7/15/13, at 5:35 p.m. one fly was noted to fly around R72's resident room. During an observation and interview on 7/15/13, at 5:46 p.m. a fly swatter was noted to be in R58's room. Upon inquiry, R58 reported that the facility staff utilized the fly swatter to kill flies in her room. During an observation and interview on 7/15/13,	F 469	F469 Pierz Villa is in disagreement with this deficiency, however we will attempt to remedy the deficiency to the best of our ability. -It shall be known that Pierz Villa is located in a small rural farming community in which it is likely not possible to totally eliminate flies in our facility. The week that MDH was at the facility the weather was unusually hot and humid. Most days humidity levels were in the 90's with temperatures in the high 80's /low 90's. Pierz Villa's main entrance also sits about 40 feet from the dining room entrance. The patio door sits 40-50 feet away from the dining room entrance also. The main entrance has handicapped doors that are used frequently throughout each day. -Even though R20 and R27 have carried a flyswatter they have never complained of a fly problem at the facility. It should also be noted that R20 attended Resident council on 7/24 and did not express any concern at that time either. R19 made a comment to MDH that "They're bad this year". It should be known R19 has only lived at facility for 1 ½ months.	

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F 469	Continued From page 32 at 7:10 p.m. two flies were noted to be flying around R19's resident room. R19 stated, "They're bad this year." During an observation on 7/16/13, at 9:28 a.m. a fly swatter was noted to be resting on R27's walker in his resident room. During an observation on 7/16/13, 9:56 a.m. R21 was noted to have a fly swatter lying on his over-the-bed table in his resident room. During an observation and interview on 7/16/13, at 2:20 p.m. R61 was noted to be holding a fly swatter while talking with writer in her resident room. R61 stated, "[The] flies are terrible." During an observation of the breakfast meal on 7/17/13, at 7:50 a.m. R20 was seated at a table in the main dining room. R20 was noted with a fly swatter lying on a pillow that rested on the left arm tray of her wheelchair while she and her three table mates ate breakfast. R9 was seated at another table across the dining room, with three resident table mates and one nursing assistant (NA)-B, who provided assistance to a table mate. Throughout the breakfast meal, several flies were noted in the dining room, flying around the food items that were served. One fly repeatedly landed on R9's breakfast plate. R9 verbalized a complaint that the fly was bothering her and was observed to make repeated attempts to physically remove the fly from her plate. NA-B responded, "There's that pesky fly again huh, as soon as you pull out your fly swatter it will go away, won't it." During an interview on 7/17/13, at 8:00 a.m. R20 verified she had occasionally swatted flies on the	F 469	-Pierz Villa called their pest control company on 7/19/13 and they were out on 7/23/13. They stated that we do not have a fly problem and that living in a rural farming community you are going to have flies. The company did treat main entry ways with a clear chemical. Pierz Villa is scheduled for a quarterly visit from the company in August. Pierz Villa residents will be asked about this issue at the next 2 resident council meetings or until resolved. Pierz Villa has reviewed and updated the policy. Pierz Villa will audit R9, R20, R58, R27, R21. R61 and R 72 are discharged from facility. We will include two other residents and 2 staff members weekly for the 1st month and then every other week for the next two months. These audits will be shared and discussed with the QA Committee. Pierz Villa will be in compliance by 8/28/13.	

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F 469	Continued From page 33 main dining room table, during meals. During the environmental tour on 7/18/13, at 10:30 a.m. the facility administrator and maintenance director denied any problems with pest control in the facility. The administrator reported that the recent heat and humidity likely drove some flies into the building when residents went in and out of the patio entrance doors. Weather stripping was observed by writer to be missing from the lower half of the patio door, which left an opening of approximately on quarter inch in width. The patio area outside the door was visible through the opening. The maintenance director verified the missing weather stripping had not been previously identified by the facility, but denied the weather stripping may have impacted the amount of flies within the facility. The administrator and maintenance director both denied they received any complaints of pest concerns in the facility. They also verified no efforts had been made to remedy the flies in the facility because they had not identified it as a concern. The administrator verified awareness that some of the residents routinely carried fly swatters in their walkers, on their wheel chairs or on their person, including into the dining room. The administrator agreed it was a concern that residents felt the need to carry fly swatters with them throughout the facility; however she felt the residents may have carried them for a sense of security, not due to an actual pest problem. Intermittent observations on 7/15/13 through 7/19/13 revealed flies noted in all four wings of the facility and common areas, including day rooms, hallways, conference rooms, activity rooms, resident rooms and the dining room.	F 469		

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F 469	Continued From page 34 Review of the facility's Pest Control Policy dated 4/96, noted, "An on-going pest control program shall be operational in this facility at all times." The policy described that a written contract would be drawn up between the nursing home and the pest control company that would include the services to be performed, frequency and cost.	F 469		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	F520 Pierz Villa has always had a quarterly attendance record of the quarterly QA meetings. It was presented to survey team. However, since it was not physical signatures, Pierz Villa has created a sign in sheet for all attendees to sign at each meeting. - Pierz has an infection control program in place to minimize the transmission of disease and infection, however we will implement the following measures in attempt to improve what we currently have in existence: -A resident infection control report will be completed by the RN or LPN each time a resident displays signs and symptoms of an infection or starts on an antibiotic. This form will collect the information needed to identify and track potential outbreaks or iInfection control issues. The completed form will be routed to the infection control nurse who will track and trend the data collected and put protocols in place as needed.	

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	245286	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ VILLA, INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

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F 520	Continued From page 35 Based on interview and document review, the facility's quality assurance (QA) committee failed to maintain a record of committee members that attended the QA meetings and failed to develop and implement a process for in depth analysis, improvement activities and action plans to address deficient practices in infection control monitoring and surveillance and potential abuse/neglect investigation policies/procedures which had the potential to affect all 40 residents who resided in the facility. Findings include: During interview on 7/19/13, at 11:00 a.m. administrator reported the QA committee did have the required minimum membership and quarterly meetings, but was unable to produce a sign in sheet which showed actual attendance at the meetings. The administrator stated the infection control logs were reviewed at the QA meetings however the facility infection control nurse did not attend the meetings. Instead, the logs were passed to the director of nursing to bring forth. Administrator indicated the QA committee had not discovered the infection control logs were not tracking symptoms prior to antibiotic use, staff infections in comparison to resident infections, nor was there any analysis of the data collected. In addition, administrator stated the facility's prior quarterly incident reports were reviewed at the QA meetings and then were shredded. The Administrator indicated the committee had not identified any concerns related to the lack of complete and thorough investigations in potential abuse/neglect cases, failure to protect residents	F 520	-Pierz Villa has implemented an employee report form also. This form will be filled out by each employee for any absence due to illness. This form will collect the data for the infection control nurse to analyze employee signs and symptoms compared to resident signs and symptoms of infection and allow infection control nurse to put protocols into place as needed. -A monthly summary will be completed by the infection control nurse to analyze data collected. This summary will identify any trends, if any, among residents and/or staff. This information will also be reviewed monthly with the DON for any follow-up that may be necessary. -To ensure that protocols are being followed Pierz Villa will audit that the data is being collected and analyzed on a monthly basis. -These audits and data collected will be shared and reviewed with the QA committee on an ongoing basis. -Pierz Villa will be in compliance by 8/28/13. -In order to assure that all unknown injuries that are unexplainable and are suspicious of abuse and any negligent care is thoroughly investigated and reported to the SA timely Pierz Villa has reviewed and updated the Vulnerable Adult Policy and procedures. -All staff were educated on 8/8/13 on the policies and educated on reporting guidelines.	

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F 520	Continued From page 36 during such investigations or failure to report suspected cases to the state agency. Review of the facility's Quality Assurance Plan (undated) revealed listed objectives which included identifying opportunities to improve care or problems, and to evaluate trends, issues, problems, and potential risks related to the quality of care which would be ongoing. Review of the facility's Surveillance for Nosocomial Infections policy revised 1/12, noted that surveillance data and analysis was to be presented at the quarterly Quality Assurance meeting. Review of the facility's Infection Control Program policy revised 1/12, instructed, "It shall be the responsibility of the Quality Assurance Committee through all Department Supervisors to assure that infection control policies and procedures are implemented and followed."	F 520	-All staff were educated on the revised complaint form and how to use it at their respective department meetings. -The director of Social Services has also created a log tracking book for all reports that are submitted to the SA. -An investigation form has been added to the resident incident/accident report form in which nurses complete. Education on This form will be provided on 8/27/13 to all -nursing staff. -To assure that any reports made to the SA were timely, Pierz Villa will audit all reports monthly x3 months or until resolved. Pierz Villa will also audit to see that there was a thorough investigation completed. -All tracking logs and audits will be shared and discussed with the QA committee on an ongoing basis. Pierz Villa will be in compliance By 8/28/13.	

Pierz Villa, Inc.

P.O. Box 397 • Pierz, Minnesota 56364 • Phone: 320-468-6405
www.pierzvilla.com
Equal Opportunity Employer

8/20/2013

Addendum to Plan of Corrections

Below is a list of the deficiencies being audited, along with assignment of auditing responsibility.

F156 – Joanie Vogtlin, Activities Director

F159 – Kim Rocheleau, Administrator

F225/F226 – Kim Rocheleau, Administrator

F278 – Dana Iverson, Director of Nursing

F371 – Dana Iverson, Director of Nursing

F441 – Kim Rocheleau, Administrator

F463 – Colleen Lucking, Business Office Manager

F465 – Karen Gross, Assistant Activity Director; Joanie Vogtlin, Activity Director; Elizabeth Brown-Cory, MDS/Infection Control Coordinator

F469 – Heather Kasper-Maine, LSW

Dana Iverson RN/DON 8/20/13

Dana Iverson, RN
Director of Nursing

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K 000	INITIAL COMMENTS	K 000		

Dc: 08.28.2013

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pierz Villa was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Exit: 07.19.2013

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

RECEIVED
AUG 21 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
JB 8-23-13

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

K Roch — LNHA — 8/15/13

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.

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Pierz Villa is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and is now Type V(111) construction because of a new roof system that includes wood sheathing over the existing roof system. In 1983, an addition was added to the south that was determined to be of Type V(111) construction. In 1994, another addition was added to the southeast of the that was determined to be of Type V(111) construction. Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K054 On 8/1/2013 the contracted fire protection company was out to conduct another sensitivity test in order to comply with the alternating year requirement. Pierz Villa had a pass in 2010, 2011 and now in 2013.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 12:30 PM on 07/16/2013, during a review of the available fire alarm testing documentation and an interview with the Maintenance Supervisor (CO), it was revealed that the facility was unable to provide documentation for the required alternating year sensitivity test being preformed for the 4 smoke detectors that were replaced in 2009. The facility did provide documentation that in 2010 they conducted the required sensitivity test within 1 year of replacing the 4 smoke detector heads but	K 054		

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K 054	Continued From page 3 they could not provide any documentation for the alternating year sensitivity test being conducted after the 2010 test. This deficient practice was confirmed by the Facility Manager (CO) at the time of discovery.	K 054	K056 The week of 8/12 the fire protection company will be out to correct the inoperative horn and strobe light that is located outside of the facility. Pierz Villa will be in compliance by 8/28/13.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could failures in the system or a delay in notification of a fire sprinkler activation which could affect all residents, visitors and staff of the facility. Findings include:	K 056		

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K 056	Continued From page 4 On facility tour between 10:30 AM to 12:30 PM on 07/16/2013, during the review of the available fire sprinkler documentation and an interview with the Maintenance Supervisor (CO) it was found that the outside horn and strobe was noted by the fire sprinkler testing company as being inoperative at the time of their sprinkler inspection. The facility also could not provide any documentation verifying the the outside horn and strobe was fixed at the time of this inspection This deficient practice was confirmed by the Facility Manager (CO) at the time of discovery.	K 056		