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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ZYM

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 **07/29/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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):

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/11/2014 (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
07/21/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5286

Electronically Delivered: September 11, 2014

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 July 22, 2014, 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 29, 2014

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

RE: Project Number S5286026

Dear Ms. Rocheleau:

On June 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. 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 July 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard urvey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014, effective July 22, 2014 and therefore remedies outlined in our letter to you dated June 30, 2014, 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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	7/29/2014

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/22/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/22/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	07/29/2014	16022	07/29/2014
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
6/12/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ZYM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00384

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(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 **06/12/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: 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):

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NE II 07/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Secialist 07/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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 07/21/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 30, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5286026

Dear Ms. Rocheleau:

The above facility was surveyed on June 9, 2014 through June 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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 _____	06/12/2014

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to minimize the risk for falls for 1 of 3 residents (R6) reviewed for accidents. Findings include: The NA pocket care plan updated 6/5/14, identified R6 as requiring assistance with transfers, and directed staff to ensure a RN Box was on when the resident was in the bed or chair. R6's care plan dated 1/3/14, indicated R6 was at risk for falling, and staff were to ensure her call	F 282		7/22/14

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

Electronically Signed | 07/03/2014

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 _____	06/12/2014

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 282	Continued From page 1	F 282		

light was placed within her reach.

R6 was observed seated in her wheelchair in her room on 6/10/14, at 3:37 p.m. She reported she needed to use "the potty," and activated her light that was attached to a pillow on her bed. A nursing assistant (NA)-A entered room and assisted R6 to the toilet. NA-A then reminded R6 to use the call light to let the staff know when she was finished. The surveyor then asked NA-A if R6 was able to effectively use the call light and NA-A said she was able to do so, and left the room at 3:46 p.m. At 3:50 p.m. a licensed practical nurse (LPN)-B entered R6's room to administer her medication. When informed R6 was in the bathroom alone, she stated the resident was not to be left alone in the bathroom due to her fall history and alarm use. LPN-B then assisted R6 off the toilet and into her wheelchair.

On 6/11/14, at 7:33 a.m. R6 was observed in her room. Her call light was unattached and laying in the middle of her bed. When asked if she could reach the light, R6 made three attempts but was unable to reach the light. Her personal alarm was sounding, and the director of nursing (DON) responded and verified the call light was out of the resident's reach.

During an interview on 6/10/14, at 3:55 p.m. LPN-B stated R6 was not to be left alone in the bathroom due to the use of the RN Box. She further explained staff was aware the resident was to use the alarm because it had been identified on the NA care plan and they had been routinely educated regarding the practice.

NA-A was interviewed on 6/10/14, at 4:00 p.m. and stated she was aware R6 had a RN Box, but

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 _____	06/12/2014

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 282	Continued From page 2 forgot she also could not leave the resident alone on the toilet. NA-A verified she had the correct information on her NA care plan and said she used it regularly for resident care. On 6/12/14, at 9:36 a.m. the DON stated she expected staff to place all call lights within residents' reach while in their rooms. She further expected staff to remain in the bathrooms of residents who utilize RN Boxes according to their policy. The Pierz Villa undated policy RN+Bed/Chair/Alarm System advised: "AT NO TIME IS A RESIDENT WHO HAS AN RN=SYSTEM LISTED ON THEIR CAREPLAN SHOULD THEY BE LEFT ALONE ON THE TOILET. THESE RESIDENTS ARE CONSIDERED A HIGH FALL RISK."	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the se of	F 315		7/22/14

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 _____	06/12/2014

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 315	Continued From page 3	F 315		

catheter was necessary for long term use for 1 of of 2 residents (R6) reviewed for catheter use.

Findings include:

R6 was observed on 6/10/14, at 2:10 p.m. with a urine collection leg bag in place. On 6/11/14, at 7:30 a.m. R6's catheter bag was being emptied by staff.

R6 was admitted to the facility in 6/13 with diagnoses including urinary retention, and had a Foley catheter inserted at the time. The Pierz Nursing Home Bladder Assessment Form dated 7/4//13, revealed a request was made to R6's primary doctor requesting post-void-residual (PVR) checks to determine whether the catheter could be removed. A nursing note written 7/4/13, verified the facility staff was awaiting response from the doctor. The physician's office returned the response via fax on 7/8/13, regarding the PVR check and discontinuation of the catheter and the response from the physician was, and noted, "No, I don't think that is needed."

During an interview on 6/10/13 at 2:30 p.m., the director of nursing (DON) explained R6 had been admitted from another long term care facility with the Foley catheter in place, and the Foley had been utilized for over three years prior to the resident's admission. She further acknowledged the facility made no attempts to discontinue use of the Foley catheter, nor had any medical evaluations or consultations with a urologist been sought.
On 6/12/14, at 8:20 a.m. the DON provided an order written 6/11/14, by R6's doctor to discontinue the Foley and straight catheterize the resident four times daily for PVR. If residual was

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	245286	A. BUILDING _____ B. WING _____	06/12/2014

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 315	Continued From page 4 greater than 250 milliliters, the Foley was to be reinserted and an appointment with a urologist made. The DON further stated R6's doctor was unsure the reason she had not wanted a trial removal of the catheter. On 6/12/14 at 11:14 a.m., the DON stated regarding the use of Foley catheters, she expected staff to do attempt to get a doctor's order for their removal, schedule urology appointments as a follow up, and ensure a proper diagnosis if the continuation was warranted. The DON stated, "It was not followed through as it should have been."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to minimize the risk for falls for 1 of 3 residents (R6) reviewed for accidents. Findings include: R6 was observed seated in her wheelchair in her room on 6/10/14, at 3:37 p.m. She reported she needed to use "the potty," and activated her light	F 323		7/22/14

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 _____	06/12/2014

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 323	Continued From page 5	F 323		

that was attached to a pillow on her bed. A nursing assistant (NA)-A entered room and assisted R6 to the toilet. NA-A then reminded R6 to use the call light to let the staff know when she was finished. The surveyor then asked NA-A if R6 was able to effectively use the call light and NA-A said she was able to do so, and left the room at 3:46 p.m. At 3:50 p.m. a licensed practical nurse (LPN)-B entered R6's room to administer her medication. When informed R6 was in the bathroom alone, she stated the resident was not to be left alone in the bathroom due to her fall history and alarm use. LPN-B then assisted R6 off the toilet and into her wheelchair.

On 6/11/14, at 7:33 a.m. R6 was observed in her room. Her call light was unattached and laying in the middle of her bed. When asked if she could reach the light, R6 made three attempts but was unable to reach the light. Her personal alarm was sounding, and the director of nursing (DON) responded and verified the call light was out of the resident's reach.

R6's Minimum Data Set (MDS) dated 3/31/14, revealed R6's Brief Interview for Mental Status (BIMS) score of 9 of 15 indicated moderate cognitive loss, and diagnoses included dementia and seizure disorder. The corresponding Care Area Assessment (CAA) identified R6 at risk for falls related to dementia, history of falls , medication including Phenobarbital (a long-acting barbiturate known to have hypnotic and sedative effects) and Lasix (a diuretic), age, and history of orthostatic hypotension (drop in blood pressure with positional changes, known to contribute to falls). The CAA further acknowledged R6 showed used the call light inconsistently. An alarm (RN Box) was applied to R6's chair. The MDS also

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F 323	Continued From page 6 identified R6 as required extensive staff assistance to transfer and toilet due to poor balance. A doctor's order on 2/10/14, directed staff to apply a RN Box while the resident was in bed and in the chair. R6 incident reports reviewed for past three months revealed that on 5/15/14, at 5:15 a.m. R6 was observed sitting on the floor as staff was conducting rounds. The RN Box alarm was sounding. On 6/4/14, at 5:45 a.m. R6 was found on floor in her bathroom, and both the call light in the room and in the bathroom were engaged. A call log for R6 revealed additional falls had occurred on 4/26, 5/20, and 5/21/14. The NA pocket care plan updated 6/5/14 identified R6 as requiring assistance with transfers, and directed staff to ensure a RN Box was on when the resident was in the bed or chair. R6's care plan dated 1/3/14, indicated R6 was at risk for falling, and staff were to ensure her call light was placed within her reach. During an interview on 6/10/14, at 3:55 p.m. LPN-B stated R6 was not to be left alone in the bathroom due to the use of the RN Box. She further explained staff was aware the resident was to use the alarm because it had been identified on the NA care plan and they had been routinely educated regarding the practice. NA-A was interviewed on 6/10/14, at 4:00 p.m. and stated she was aware R6 had a RN Box, but forgot she also could not leave the resident alone on the toilet. NA-A verified she had the correct information on her NA care plan and said she	F 323		

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F 323	Continued From page 7 used it regularly for resident care. On 6/12/14, at 9:36 a.m. the DON stated she expected staff to place all call lights within residents' reach while in their rooms. She further expected staff to remain in the bathrooms of residents who utilize RN Boxes according to their policy. The Pierz Villa undated policy RN+Bed/Chair/Alarm System advised: "AT NO TIME IS A RESIDENT WHO HAS AN RN=SYSTEM LISTED ON THEIR CAREPLAN SHOULD THEY BE LEFT ALONE ON THE TOILET. THESE RESIDENTS ARE CONSIDERED A HIGH FALL RISK."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		7/22/14

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F 329	Continued From page 8 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide justification for lack of a gradual dose reduction for antidepressant use for 1 of 5 residents reviewed (R18) for unnecessary medication use. Findings include: R18 was prescribed the antidepressants Celexa 20 milligrams (mg) and Remeron 45 mg for a diagnosis of depression. No gradual dose reduction (GDR) had been attempted since 6/28/13, at the time R18 was admitted to the facility with the medications. Although the pharmacist requested a justification from the doctor for lack of trial dose reduction, the medical record lacked such a written justification. The pharmacist completed medication reviews monthly and pertinent reviews were as follows: 1) A review dated 9/4/13, read, "MD [medical doctor] reviewed 8/20/13 GDR for Ambien, Restoril [both for sleep], Remeron and Celexa. If dictation does not include all of the above, please ask MD to document rationale why dose reduction Ambien, Restoril, Remeron or Celexa is or is not possible." 2) On 11/1/13, "both Celexa and Remeron at lowest doses, dictation for rationale 10/22/13 pending, check next visit."	F 329		

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F 329	Continued From page 9 3) On 2/5/14, "Reminder, if Remeron, Celexa can not be decreased please document reason why." 4) On 4/1/14, "Please address dose reduction reasons for Ativan, Celexa, and Remeron in coming month or two--if not done last month. Make sure non-drug approaches are explored. A physician justification was provided on 4/29/14, for the use of Ativan at the current does for increased episodes of shortness of breath, crying and anxiety symptoms. 5) On 6/2/14, "For ongoing documentation please ask MD to specifically document if a gradual dose reduction attempt is possible. If not, document why a dose reduction for either Celexa or Remeron is not possible." Physician progress notes were reviewed. The note dated 10/7/13, lacked notation regarding any dose reductions. The note dated 11/29/13, mentioned, " No changes to meds" [medications]. The note dated 2/18/14, lacked notation regarding dose reductions or status of her depression. The review dated 3/11/14, lacked notation regarding dose reductions or status of her depression. The note dated 4/29/14, indicated a justification for not reducing Ambien, as many attempts had been tried and failed, but lacked documentation regarding Celexa and Remeron use. The director of nursing (DON) was interviewed on 6/11/14, at 1:30 p.m. and R18's record was reviewed. The DON verified the record lacked a justification for no GDR for antidepressant use. The DON explained that the system for notifying the MD of pharmacy requests was to copy the pharmacy notes, highlight pertinent information and place in the doctors folder for review at the next visit. The folder was reviewed and found to	F 329		

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F 329	Continued From page 10 contain the pharmacy notes from 6/2/14, with highlighted area concerning GDR to be addressed. However, previous pharmacy notes from 9/13 to 4/14 recommended a justification and the record lacked documentation of a response. The DON went on to explain that R18 was a very depressed person and on admit she displayed self-isolation, anxiety and had paranoid thinking, but at present was improved and not displaying the paranoia. The DON explained that R18 saw a mental health counselor on a regular basis which has helped her tremendously. On 6/11/14, at 9:00 a.m. the social worker (SW) reported R18 was getting out to church regularly now, and had become involved in resident council. R18's care plan identified a problem related to the use of psychotropic medications for generalized anxiety, insomnia and depression, with a goal for no exacerbation of anxiety symptoms in the next the months. Interventions included GDR per facility protocol. The current facility policy titled Psychotropic Medications indicated physicians and mid-level providers will use psychotropic medications appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The policy directed physicians to attempt a gradual dose reduction bi-annually for psychotropic medications unless clinically contraindicated.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		7/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 11 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to correctly post nursing staffing hours for each shift as required potentially affecting all residents and visitors to the facility. Findings include:	F 356		

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F 356	Continued From page 12 During the initial observation tour on 6/9/14, at 2:51 p.m. the number of hours worked by each staff discipline for each shift was seen to be posted under the name of the shift: "Days," for example; but the hours spanned by each shift were not specified: "6:30 a.m. to 3:00 p.m." for example. The observed hours postings were consistent with the facility's Daily Staffing Hours and Posting policy. On 6/12/14, at 10:41 a.m. the director of nursing (DON) verified the copies of staffing hours provided by the administrator on 6/10/14, were in the usual form the facility used for such postings.	F 356		

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/12/2014**

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K 000	INITIAL COMMENTS 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 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. 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 corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Electronically Delivered: June 30, 2014

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

RE: Project Number S5286026

Dear Ms. Rocheleau:

On June 12, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

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

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

Remedies - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 July 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your

ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 September 12, 2014 (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 December 12, 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 an ePoC 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
Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00384	A. BUILDING: _____ B. WING _____	06/12/2014

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/10/14 through 6/12/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column	

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2 000	Continued From page 1 Certification Program; PO Box 64900, Saint Paul, MN 55164-0900	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 565		

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2 565	Continued From page 2 review, the facility failed to follow the care plan to minimize the risk for falls for 1 of 3 residents (R6) reviewed for accidents. Findings include: The NA pocket care plan updated 6/5/14, identified R6 as requiring assistance with transfers, and directed staff to ensure a RN Box was on when the resident was in the bed or chair. R6's care plan dated 1/3/14, indicated R6 was at risk for falling, and staff were to ensure her call light was placed within her reach. R6 was observed seated in her wheelchair in her room on 6/10/14, at 3:37 p.m. She reported she needed to use "the potty," and activated her light that was attached to a pillow on her bed. A nursing assistant (NA)-A entered room and assisted R6 to the toilet. NA-A then reminded R6 to use the call light to let the staff know when she was finished. The surveyor then asked NA-A if R6 was able to effectively use the call light and NA-A said she was able to do so, and left the room at 3:46 p.m. At 3:50 p.m. a licensed practical nurse (LPN)-B entered R6's room to administer her medication. When informed R6 was in the bathroom alone, she stated the resident was not to be left alone in the bathroom due to her fall history and alarm use. LPN-B then assisted R6 off the toilet and into her wheelchair. On 6/11/14, at 7:33 a.m. R6 was observed in her room. Her call light was unattached and laying in the middle of her bed. When asked if she could reach the light, R6 made three attempts but was unable to reach the light. Her personal alarm was sounding, and the director of nursing (DON) responded and verified the call light was out of the resident's reach.	2 565		

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2 565	Continued From page 3 During an interview on 6/10/14, at 3:55 p.m. LPN-B stated R6 was not to be left alone in the bathroom due to the use of the RN Box. She further explained staff was aware the resident was to use the alarm because it had been identified on the NA care plan and they had been routinely educated regarding the practice. NA-A was interviewed on 6/10/14, at 4:00 p.m. and stated she was aware R6 had a RN Box, but forgot she also could not leave the resident alone on the toilet. NA-A verified she had the correct information on her NA care plan and said she used it regularly for resident care. On 6/12/14, at 9:36 a.m. the DON stated she expected staff to place all call lights within residents' reach while in their rooms. She further expected staff to remain in the bathrooms of residents who utilize RN Boxes according to their policy. The Pierz Villa undated policy RN+Bed/Chair/Alarm System advised: "AT NO TIME IS A RESIDENT WHO HAS AN RN=SYSTEM LISTED ON THEIR CAREPLAN SHOULD THEY BE LEFT ALONE ON THE TOILET. THESE RESIDENTS ARE CONSIDERED A HIGH FALL RISK." SUGGESTED METHOD OF CORRECTION: Re-education of staff could be provided for pertinent staff regarding care plans and the importance of following them for each resident. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to minimize the risk for falls for 1 of 3 residents (R6) reviewed for accidents, and to ensure the use of catheter was necessary for long term use for 1 of of 2 residents (R6) reviewed for catheter use. Findings include: R6 was observed seated in her wheelchair in her room on 6/10/14, at 3:37 p.m. She reported she needed to use "the potty," and activated her light that was attached to a pillow on her bed. A nursing assistant (NA)-A entered room and assisted R6 to the toilet. NA-A then reminded R6 to use the call light to let the staff know when she was finished. The surveyor then asked NA-A if R6 was able to effectively use the call light and NA-A said she was able to do so, and left the	2 830		

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2 830	Continued From page 5 room at 3:46 p.m. At 3:50 p.m. a licensed practical nurse (LPN)-B entered R6's room to administer her medication. When informed R6 was in the bathroom alone, she stated the resident was not to be left alone in the bathroom due to her fall history and alarm use. LPN-B then assisted R6 off the toilet and into her wheelchair. On 6/11/14, at 7:33 a.m. R6 was observed in her room. Her call light was unattached and laying in the middle of her bed. When asked if she could reach the light, R6 made three attempts but was unable to reach the light. Her personal alarm was sounding, and the director of nursing (DON) responded and verified the call light was out of the resident's reach. R6's Minimum Data Set (MDS) dated 3/31/14, revealed R6's Brief Interview for Mental Status (BIMS) score of 9 of 15 indicated moderate cognitive loss, and diagnoses included dementia and seizure disorder. The corresponding Care Area Assessment (CAA) identified R6 at risk for falls related to dementia, history of falls , medication including Phenobarbital (a long-acting barbiturate known to have hypnotic and sedative effects) and Lasix (a diuretic), age, and history of orthostatic hypotension (drop in blood pressure with positional changes, known to contribute to falls). The CAA further acknowledged R6 showed used the call light inconsistently. An alarm (RN Box) was applied to R6's chair. The MDS also identified R6 as required extensive staff assistance to transfer and toilet due to poor balance. A doctor's order on 2/10/14, directed staff to apply a RN Box while the resident was in bed and in the chair.	2 830		

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2 830	Continued From page 6 R6 incident reports reviewed for past three months revealed that on 5/15/14, at 5:15 a.m. R6 was observed sitting on the floor as staff was conducting rounds. The RN Box alarm was sounding. On 6/4/14, at 5:45 a.m. R6 was found on floor in her bathroom, and both the call light in the room and in the bathroom were engaged. A call log for R6 revealed additional falls had occurred on 4/26, 5/20, and 5/21/14. The NA pocket care plan updated 6/5/14 identified R6 as requiring assistance with transfers, and directed staff to ensure a RN Box was on when the resident was in the bed or chair. R6's care plan dated 1/3/14, indicated R6 was at risk for falling, and staff were to ensure her call light was placed within her reach. During an interview on 6/10/14, at 3:55 p.m. LPN-B stated R6 was not to be left alone in the bathroom due to the use of the RN Box. She further explained staff was aware the resident was to use the alarm because it had been identified on the NA care plan and they had been routinely educated regarding the practice. NA-A was interviewed on 6/10/14, at 4:00 p.m. and stated she was aware R6 had a RN Box, but forgot she also could not leave the resident alone on the toilet. NA-A verified she had the correct information on her NA care plan and said she used it regularly for resident care. On 6/12/14, at 9:36 a.m. the DON stated she expected staff to place all call lights within residents' reach while in their rooms. She further expected staff to remain in the bathrooms of residents who utilize RN Boxes according to their policy.	2 830		

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2 830	Continued From page 7 The Pierz Villa undated policy RN+Bed/Chair/Alarm System advised: "AT NO TIME IS A RESIDENT WHO HAS AN RN=SYSTEM LISTED ON THEIR CAREPLAN SHOULD THEY BE LEFT ALONE ON THE TOILET. THESE RESIDENTS ARE CONSIDERED A HIGH FALL RISK." R6 was observed on 6/10/14, at 2:10 p.m. with a urine collection leg bag in place. On 6/11/14, at 7:30 a.m. R6's catheter bag was being emptied by staff. R6 was admitted to the facility in 6/13 with diagnoses including urinary retention, and had a Foley catheter inserted at the time. The Pierz Nursing Home Bladder Assessment Form dated 7/4//13, revealed a request was made to R6's primary doctor requesting post-void-residual (PVR) checks to determine whether the catheter could be removed. A nursing note written 7/4/13, verified the facility staff was awaiting response from the doctor. The physician's office returned the response via fax on 7/8/13, regarding the PVR check and discontinuation of the catheter and the response from the physician was, and noted, "No, I don't think that is needed." During an interview on 6/10/13 at 2:30 p.m., the director of nursing (DON) explained R6 had been admitted from another long term care facility with the Foley catheter in place, and the Foley had been utilized for over three years prior to the resident's admission. She further acknowledged the facility made no attempts to discontinue use of the Foley catheter, nor had any medical evaluations or consultations with a urologist been sought. On 6/12/14, at 8:20 a.m. the DON provided an	2 830		

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2 830	Continued From page 8 order written 6/11/14, by R6's doctor to discontinue the Foley and straight catheterize the resident four times daily for PVR. If residual was greater than 250 milliliters, the Foley was to be reinserted and an appointment with a urologist made. The DON further stated R6's doctor was unsure the reason she had not wanted a trial removal of the catheter. On 6/12/14 at 11:14 a.m., the DON stated regarding the use of Foley catheters, she expected staff to do attempt to get a doctor's order for their removal, schedule urology appointments as a follow up, and ensure a proper diagnosis if the continuation was warranted. The DON stated, "It was not followed through as it should have been." SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure residents at risk for falls have been comprehensively assessed and appropriate interventions are in place and followed by staff. Residents who utilize catheters could be assessed for the appropriate use and trial discontinuation if possible. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug	21535		

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21535	Continued From page 9 therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide justification for lack of a gradual dose reduction for antidepressant use for 1 of 5 residents reviewed (R18) for unnecessary medication use. Findings include: R18 was prescribed the antidepressants Celexa 20 milligrams (mg) and Remeron 45 mg for a diagnosis of depression. No gradual dose reduction (GDR) had been attempted since 6/28/13, at the time R18 was admitted to the facility with the medications. Although the pharmacist requested a justification from the doctor for lack of trial dose reduction, the medical record lacked such a written justification.	21535		

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21535	Continued From page 10 The pharmacist completed medication reviews monthly and pertinent reviews were as follows: 1) A review dated 9/4/13, read, "MD [medical doctor] reviewed 8/20/13 GDR for Ambien, Restoril [both for sleep], Remeron and Celexa. If dictation does not include all of the above, please ask MD to document rationale why dose reduction Ambien, Restoril, Remeron or Celexa is or is not possible." 2) On 11/1/13, "both Celexa and Remeron at lowest doses, dictation for rationale 10/22/13 pending, check next visit." 3) On 2/5/14, "Reminder, if Remeron, Celexa can not be decreased please document reason why." 4) On 4/1/14, "Please address dose reduction reasons for Ativan, Celexa, and Remeron in coming month or two--if not done last month. Make sure non-drug approaches are explored. A physician justification was provided on 4/29/14, for the use of Ativan at the current does for increased episodes of shortness of breath, crying and anxiety symptoms. 5) On 6/2/14, "For ongoing documentation please ask MD to specifically document if a gradual dose reduction attempt is possible. If not, document why a dose reduction for either Celexa or Remeron is not possible." Physician progress notes were reviewed. The note dated 10/7/13, lacked notation regarding any dose reductions. The note dated 11/29/13, mentioned, " No changes to meds" [medications]. The note dated 2/18/14, lacked notation regarding dose reductions or status of her depression. The review dated 3/11/14, lacked notation regarding dose reductions or status of her depression. The note dated 4/29/14, indicated a justification for not reducing Ambien, as many attempts had been tried and failed, but	21535		

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21535	Continued From page 11 lacked documentation regarding Celexa and Remeron use. The director of nursing (DON) was interviewed on 6/11/14, at 1:30 p.m. and R18's record was reviewed. The DON verified the record lacked a justification for no GDR for antidepressant use. The DON explained that the system for notifying the MD of pharmacy requests was to copy the pharmacy notes, highlight pertinent information and place in the doctors folder for review at the next visit. The folder was reviewed and found to contain the pharmacy notes from 6/2/14, with highlighted area concerning GDR to be addressed. However, previous pharmacy notes from 9/13 to 4/14 recommended a justification and the record lacked documentation of a response. The DON went on to explain that R18 was a very depressed person and on admit she displayed self-isolation, anxiety and had paranoid thinking, but at present was improved and not displaying the paranoia. The DON explained that R18 saw a mental health counselor on a regular basis which has helped her tremendously. On 6/11/14, at 9:00 a.m. the social worker (SW) reported R18 was getting out to church regularly now, and had become involved in resident council. R18's care plan identified a problem related to the use of psychotropic medications for generalized anxiety, insomnia and depression, with a goal for no exacerbation of anxiety symptoms in the next the months. Interventions included GDR per facility protocol. The current facility policy titled Psychotropic Medications indicated physicians and mid-level providers will use psychotropic medications	21535		

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21535	Continued From page 12 appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The policy directed physicians to attempt a gradual dose reduction bi-annually for psychotropic medications unless clinically contraindicated. SUGGESTED METHOD OF CORRECTION: The DON or designee could devise a system to ensure pharmacy reccommendations are communicated to the physician and receive timely and complete follow up. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		