Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 21, 2025

Administrator
Pierz Villa Inc
119 Faust Street Southeast
Pierz, MN 56364

RE: CCN: 245286
Cycle Start Date: December 13, 2024

Dear Administrator:

On February 13, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2024

Administrator
Pierz Villa Inc
119 Faust Street Southeast
Pierz, MN 56364

RE: CCN: 245286
Cycle Start Date: December 13, 2024

Dear Administrator:

On December 13, 2024, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 13, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by June 13, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	C 12/13/2024

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
E 000	Initial Comments On 12/9/24 through 12/13/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/9/24 through 12/13/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52862062C MN00105930 The following complaints were reviewed. MN00108468 H52861586C was unsubstantiated however incidental findings were cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2025

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.

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 _____	C 12/13/2024

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess or re-assess and, if needed, develop interventions to promote safety and reduce the risk of injury or impairments for 1 of 2 residents (R40) reviewed for assessments. Findings include: Significant change of status minimum data set (MDS) dated 6/7/24, indicated R40 was admitted to the facility on 4/30/24, was cognitively intact, displayed no behaviors, and had the following diagnoses: pulmonary embolism (a life-threatening condition that occurs when a blood clot blocks an artery in the lungs), generalized weakness and restless leg syndrome (a neurological disorder that causes uncomfortable feelings in the legs). Additionally, the MDS indicated R40 was dependent on staff	F 689	•It is the practice of the Pierz Villa to ensure its residents living at the facility remain free of accident and injury as possible, and to ensure all residents receive adequate supervision and assistance as needed, to prevent accident or injury. •Regarding cited resident: R40 is no longer at the facility. •Identification of At-Risk residents: All residents residing in the facility have the potential to be affected by the deficient practice. To ensure other residents at the Pierz Villa are not subject to the same deficient practice, all residents, that require the use of a mechanical lift (hoyer and or EZ Stand), will be evaluated for proper transfer techniques by the Case Manager or other designee, such as Physical Therapy. Those residents found	2/7/25

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F 689	Continued From page 2 for toileting, mobility, transfers, and required substantial assistance for bathing, upper, and lower body dressing. Nursing progress notes indicated R40 had a syncopal episode (a brief loss of consciousness caused by a sudden drop in blood flow to the brain) on 7/5/24, 8/9/24, 9/5/24, and 9/13/24, while being transferred with an e-z stand lift (a device used to assist a person from a sitting to a standing position). R40's medical record lacked evidence of an assessment after each episode, vital signs taken, or re-assessment for transfer status. Further, the care plan lacked interventions to guide staff with safe transfers in the event of a syncopal episode. During interview on 12/11/24 at 10:01 a.m., registered nurse (RN)A stated any resident who had a syncopal episode would immediately be evaluated by staff, have vital signs taken and if the episode happened during a transfer, the resident would be re-assessed for transfer safety. RN-A went on to say it was important to obtain vital signs and assess after a syncopal episode to identify any concerns and determine if a resident needed to be evaluated in an emergency room. RN-A stated if a resident had a history of syncopal episodes, it would be indicated on the care plan and interventions would be in place to ensure staff followed appropriate interventions for the resident. During interview on 12/11/24, at 12:31 p.m. director of nursing (DON) stated she was aware R40 had multiple syncopal episodes. DON stated she expected staff to do an assessment, including vital signs, after any syncopal episode. Furthermore, she expected R40's care plan and	F 689	to have an improper mode of transfer will have a plan of care reviewed and updated to the accurate mode of transfer as recommended from the Case Manager or other designee such as Physical Therapy. New admissions will have a transfer mode determined via physical therapy screening. •Policy and Procedures reviewed and updated. •Education will be provided as follows: all staff will be educated to reporting a resident change of condition; all direct care staff will be educated on the proper transfer techniques and guidelines, including how to upgrade a resident's mode of transfer when appropriate, to keep the resident safe. •The Director of Nursing or designee will complete transfer audits on 3 residents per week, x4 weeks, then 5 residents per month x2 months. •Quality Assurance: Director of Nursing or designee will review and discuss audit findings with QA/QAPI committee at facility's QA/QAPI meeting. The QA/QAPI committee to determine the need for on-going monitoring. •Date of Compliance: Pierz Villa will be in compliance by February 7, 2025.	

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F 689	Continued From page 3 the staff pocket care plans to include R40's history of syncopal episodes and include guidelines to direct staff care. DON confirmed R40's medical record lacked evidence of any assessments or vital signs being taken after each syncopal episode. Further, R40's care plan lacked specific staff guidance on syncopal episodes. DON stated it was important to obtain vital signs immediately after a syncopal episode to assist in identifying any significant changes and assess if R40 needed to be transferred to a higher level of care for evaluation. A policy on assessments was requested but not provided.	F 689		

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

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PIERZ VILLA INC	**119 FAUST STREET SOUTHEAST** **PIERZ, MN 56364**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/10/2024. At the time of this survey, Pierz Villa was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 was determined to be Type II(000) construction. 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 were not of common construction	K 000		

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K 000	Continued From page 2 types the facility was inspected to a Type V(000) construction. Since the original building and the 3 additions were constructed prior to 2003 the were inspected as existing health care buildings, the facility was surveyed as one building. The building is fully fire sprinkler protect. 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 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		1/31/25

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K 321	Continued From page 3 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/10/2024 at 10:55 AM, it was revealed by observation patient rooms 217 and 218 are being used for combustible storage and did not have a door closer on the doors. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 321	•It is the practice of the Pierz Villa to comply with NFPA regulations. •A door closer apparatus to be placed on the inside of the specified room doors (217, 218) on by the Environmental Service Director. •The Environmental Service Director or designee will inspect all rooms within the facility that contain combustible materials and ensure those doors have a door closure apparatus placed. •The Facility Administrator reviewed the Life Safety Code referenced with the Environmental Service Director on January 7, 2025. Environmental Service Director to educate Environmental Service staff, on the importance of having door closure apparatus on all doors that fall into this category. •The Environmental Service Director or designee will perform audits weekly for 4 weeks to ensure closures are placed appropriately and are in working order. •The Environmental Service Director or designee will review the audit findings with the facility's Safety Committee. These	

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K 321	Continued From page 4	K 321	findings will also be shared with the facility's Quality Assurance team for further determination of the need for on-going monitoring. •Date of Compliance: Pierz Villa will be in compliance by January 31, 2025.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1, 5.2.1.2 and 5.3.2.1. These deficient findings could have a patterened	K 353	•It is the practice of the Pierz Villa to comply with NFPA regulations. •The Environmental Service Director or designee will contact the facility's fire protection company that monitors and inspects the system routinely, to schedule a site visit to inspect all sprinkler heads within the facility and correct deficient	2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

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
K 353	Continued From page 5 impact on the patients within the facility. Findings include: 1. On 12/10/2024 at 10:30 AM, it was revealed by observation dust covered sprinkler heads in the kitchen. 2. On 12/10/2024 at 10:20 AM, it was revealed by observation a paint covered sprinkler head in the soiled utility in the south corridor. An interview with the Environmental Services Director verfied these deficient findings at the time of discovery.	K 353	findings. •All sprinkler heads within the facility will be assessed quarterly to ensure sprinkler heads are free from dust and foreign material. •The Environmental Services Director or designee will educate staff on the regulation and the process of reporting their observations. •The Environmental Services Director or designee will complete audits on the sprinkler heads within the facility weekly x4 weeks and then every other month x2 months, to ensure the sprinkler heads are free from dust and any foreign material. •Quality Assurance: Environmental Service Director or designee will review and discuss audit findings with QA/QAPI committee at facility's QA/QAPI meeting. The QA/QAPI committee to determine the need for on-going monitoring. •Date of Compliance: Pierz Villa will be in compliance by February 7, 2025.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

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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K 920	Continued From page 6 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a isolated impact on the residents within the facility. Findings include: 1. On 12/10/2024 at 10:45 AM, it was revealed by observation that medical equipment was plugged into a non-hospital grade power strip in resident room 214. 2.On 12/10/2024 at 10:45 AM, it was revealed by observation that a multi-plug adapter was being used in the outlet for a TV and multiple other devices in resident room 214. An interview with the Environmental Services Director verfied these deficient findings at the time of discovery.	K 920	•It is the practice of the Pierz Villa to comply with NFPA regulations. •Upon discovery of the deficient finding, the Environmental Service Director immediately removed the discovered non-hospital grade power strip from room 214 and replaced it with an approved power strip. •The Environmental Service Director or designee will complete audits by inspecting all other areas of the building, to attempt to mitigate the use of non-compliant apparatuses within the facility. •The Environmental Service Director or designee will provide education to all staff on being observant while in resident(s) rooms or other areas of the facility that the use of non-approved power supply are not allowed. •The Environmental Service Director or designee will review the audit findings with the facility's Safety Committee. These findings will be reviewed and shared with the facility's Quality Assurance team for	

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

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K 920	Continued From page 7	K 920	further determination of the need for on-going monitoring. •Compliance date: February 7, 2025.	