DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2020

CMS Certification Number (CCN): 245286

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

Dear Administrator:

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 October 15, 2020 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2020

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

RE: CCN: 245286
Cycle Start Date: August 18, 2020

Dear Administrator:

On September 14, 2020, we notified you a remedy was imposed. On October 23, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 15, 2020.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 20, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 14, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 20, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 15, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EQ9S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00384

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

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

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

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

6. DATE OF SURVEY **08/20/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Renee Anderson, HFE NE II 10/07/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/19/2020 (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:

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
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 14, 2020

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

RE: CCN: 245286
Cycle Start Date: August 20, 2020

Dear Administrator:

On August 20, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 20, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 20, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 20, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 20, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Pierz Villa Inc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 20, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 February 20, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 08/20/2020

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/17/2020 - 8/20/2020, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On August 17, 2020 through August 20, 2020, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. Complaint H5286030C was substantiated at F689, at past non-compliance. Although the provider had implemented corrective action prior to survey, harm was sustained prior to the correction. No Plan of Correction is required for F689. The following complaints were found to be substantiated: H5286028C. No deficiency cited. The following complaints were found unsubstantiated: H5286029C H5286027C H5286031C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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

Electronically Signed | 09/24/2020

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 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 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		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		10/15/20

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 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a dignified manner for 1 of 2 residents (R22), reviewed for dignity. Findings include: R22's admission Minimum Data Set (MDS), dated 6/25/20, identified R22 was able to make himself understood and his speech was clear. The MDS further identified R22 had diagnosis which included chronic obstructive pulmonary disorder (COPD), iron deficiency anemia, and hypertension, had intact cognition, and required assistance for bed mobility, transfers, ambulation, dressing and toileting. During observation and interview on 8/17/20, at 5:20 p.m. R22's oxygen nasal cannula was noted taped to his face using clear plastic tape. R22 stated he taped the cannula to his face, because, "It won't stay in my nose, so I tape it." R22 further stated he talked with a facility staff member on 8/16/20, about getting a mask to use instead. R22 reported he was told, 'maybe a mask will work,' but a mask was not brought in for R22 to try. During observation on 8/18/20, at 1:52 p.m. R22 was outside at an activity. Nasal cannula was	F 550	Pierz Villa has the expectation that team members respects the resident right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. R22 was discharged from facility on 9/17/2020 to home. On 8/21/2020 RN consulted with Northwest Respiratory Services to help with R22□s nasal cannula placement, with no recommendations. On 8/21/2020 DON retrieved an oxygen mask for R22 to wear throughout day and educated resident he would need to wear nasal cannula for meals. R22 was in agreement with that plan. On 9/17/2020 all other residents with nasal cannulas were observed and it was identified that their nasal cannulas were appropriately placed and no tape was noted to hold nasal cannula in place. On 9/22/2020 Promoting of Resident Dignity policy and procedure were reviewed with no changes noted. On 9/22/2020 Pierz Villa team members were educated via email on Promoting Resident Dignity.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 550	Continued From page 3 secured to his nose with clear plastic, medical tape. During observation and interview on 8/18/20, at 2:17 p.m. R22 was in his room. The nasal cannula was taped to his face with clear plastic medical tape. Tape was placed under his nose and reached to each cheek, under his eyes. R22 stated, "I have to go to radiation with this tape on my face. I'm not happy about that. I think a mask would look a lot nicer. This tape looks ridiculous." During observation and interview on 8/19/20, at 7:12 a.m. R22 was resting in bed with the nasal cannula in his nose, taped to the bridge of his nose, as well as under his nose to both lower cheeks, with clear, plastic medical tape. R22 stated he was given the tape by one of the nurses. R22 further stated he again talked with one of the facility staff, in the evening on 8/18/20, about trying an oxygen mask. R22 did not recall the name of the staff he talked with. R22 stated, "They brought in a mask for the nebulizer but not for the oxygen." R22 stated the response to his request was, 'I don't know if we have any.' R22 stated "I think a mask would look a lot nicer, but I have to keep this in my nose so I need to do something." During observation on 8/19/20, at 9:18 a.m. R22's nasal cannula remained taped across the bridge and under his nose, and across both cheeks, with clear plastic medical tape. R22 was brought out of his room and to the entrance of the facility to leave for an appointment. R22 left the facility with nasal cannula taped to his face. During observation on 8/20/20, at 8:27 a.m. R22's nasal cannula tubing was around his ears with	F 550	Pierz Villa nursing team members will be further educated on 10/5/2020; 10/7/2020; 10/8/2020; 10/11/2020; 10/12/2020. Audits will be conducted on all new admissions weekly for 2 months. Current residents with nasal cannulas will be audited for appropriate placement of the cannula monthly for 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020.	

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 08/20/2020

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PIERZ VILLA INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

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F 550	Continued From page 4 gray foam protectors. The oxygen tubing was under R22's nose, with white paper tape securing it over the bridge of his nose, and the edges of the tape were loose and peeling up. Clear, plastic medical tape was observed across the bottom of his nose to above both cheek bones, the edges of the tape were loose. During interview on 8/20/20, at 8:42 a.m. registered nurse (RN)-A stated R22 taped the nasal cannula himself, because, "He thinks it stays in there better." RN-A stated she talked with R22 about a face mask on 8/19/20, and stated, "I explained he could do the facemask, but he said he would want to take it off to eat." RN-A further stated R22 had not asked RN-A about a mask before that conversation. RN-A confirmed the tape does not look good and does not look dignified and stated, "I wouldn't want to look like that." During interview on 8/20/20, at 10:11 a.m. director of nursing (DON) stated, "He is the one that requests to put it there because his nasal cannula won't stay in." DON confirmed the tape makes him feel undignified. Facility policy for dignity requested but was not provided.	F 550		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		10/15/20

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F 623	Continued From page 5	F 623		

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

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F 623	Continued From page 6 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

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F 623	Continued From page 7 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 1 of 2 residents (R22) upon transfer to the hospital. This had the potential to affect all residents transfers. In addition, the facility failed to notify the Ombudsman for Long Term Care of resident's transfer to the hospital for 1 of 2 residents (R22), reviewed for hospitalization. Findings include: R22's face sheet printed 8/20/20, indicated R22 diagnoses included malignant neoplasm of left main bronchus (lung cancer), Ischemic cardiomyopathy (a condition of weakened heart muscles), atrial fibrillation (irregular heartbeat), pleural effusion (excessive fluid around the lungs) and bronchial obstruction (a blockage in the airway). Progress notes dated 6/27/20, indicated an on call doctor was updated by facility licensed staff when R22 complained of loss of appetite and could not eat his food. Licensed staff assessment include the following findings: temperature 100.7 F, blood pressure 108/64, pulse 106, oxygen saturation 82% (oxygen level in blood),	F 623	Pierz Villa strives to ensure both the resident representative and the Office of the State Long-Term Care Ombudsman are notified of all transfers from the facility. The facility has the expectation that staff will show competence with the continued compliance of the following plan. Notification of R22s discharge to hospital was sent to Ombudsman on August 19, 2020. R22 has discharged home as of 9/17/2020. The facility □Notice of Transfer or Discharge□ policy was reviewed and updated on September 22, 2020. Licensed nursing staff education began on September 15, 2020 regarding the need to provide the Notice of Transfer/Discharge to all residents and or resident representatives when a transfer or discharge from the facility occurs. All transfers/discharges will continue to be reported to the Office of the State Long-Term Care Ombudsman monthly. Audits will be conducted weekly times four	

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F 623	Continued From page 8 respirations 18, and lung sounds wheezes bilaterally. The progress noted further noted that R22 was sent to the hospital as advised by the on call doctor. Progress note dated 6/28/20 indicated R22 was admitted to the hospital for pneumonia and stable gastrointestinal bleed. R22's medical record lacked evidence of notification of the Ombudsman of R22's transfer to the hospital. During interview on 8/19/20, at 3:15 p.m. licensed social worker (LSW)-A stated a fax was typically sent monthly to the Ombudsman with information of facility initiated resident transfers and discharges. LSW-A further stated the information sent included information of residents sent to and/or admitted to the hospital. The facility's Monthly Notice to MN Office of Ombudsman for Long-Term Care of Emergency Acute Care Transfers and Discharges, dated June 2020, was reviewed. R22's name was not noted on this form. LSW-A confirmed these findings, stating, "Obviously it got missed if I didn't write it down." During interview on 8/20/20, at 8:31 a.m. director of nursing (DON) stated she was not sure of the notification of reason for transfer or the notification sent to the Ombudsman and needed to defer those questions to the social worker. During interview on 8/20/20, at 8:42 a.m. registered nurse (RN)-A stated written notification was not usually sent to the resident's representative, but was usually communicated to the representative by phone. RN-A further stated the information provided by phone included the	F 623	weeks, then monthly times 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance by October 15th, 2020.	

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F 623	Continued From page 9 information for the reason the resident was transferred. R22's Progress note dated 6/27/20 lacked further evidence that R22 or R22's representative received a phone call or written notification of the reason for transfer. A facility policy regarding required notification with transfer/discharges was requested but not provided.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		10/15/20

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F 625	Continued From page 10 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 2 residents (R22), reviewed for hospitalizations. Findings include: R22's face sheet printed 8/20/20, indicated R22's diagnoses included malignant neoplasm of left main bronchus (lung cancer), ischemic cardiomyopathy (a condition of weakened heart muscles), atrial fibrillation (irregular heartbeat), pleural effusion (excessive fluid around the lungs) and bronchial obstruction (a blockage in the airway). R22's progress note dated 7/14/20, indicated R22 was transferred to the hospital due to chest x-ray findings of a rib fracture. R22's progress note dated 7/20/20, at 3:53 p.m. indicated R22 was readmitted to the facility. Review of R22's clinical record, including progress notes, lacked evidence that neither R22 nor R22's representative were informed of the bed hold policy at the time of hospitalization. During interview on 8/19/20, at 3:15 p.m. social worker (SW)-A stated the normal process was to provide the bed hold policy and to send the copy of the bed hold with the resident.	F 625	Pierz Villa strives to ensure that all residents and resident representative are provided with a written notice which specifies the duration of the Bed-Hold Policy when a resident is transferred to a hospital or is going on a therapeutic leave. Facility expectation is that staff will show competence with continued compliance of the following plan. Resident (R22) has since discharged home as of 9/17/2020. The facility Bed-Hold policy and procedure was reviewed and updated on September 22, 2020. Licensed nursing staff education began September 15, 2020 regarding the need to provide the facilities Bed-Hold policy and procedure to all residents and or resident representative when a transfer or discharge from the facility occurs. Audits will be conducted weekly times four weeks, then monthly times 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance by October 15th, 2020.	

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F 625	Continued From page 11 During interview on 8/20/20, at 8:11 a.m. SW-A stated a bed hold probably wasn't done because the facility thought he was going to the emergency room then coming right back. SW-A further stated R22 was not called to ask about the bed hold because SW-A was not aware of where he transferred to. SW-A stated she would normally have done the bed hold. During interview on 8/20/20, at 8:31 a.m. director of nursing (DON) stated the bed hold was signed by the resident if they left the facility and were able to sign, otherwise a verbal agreement was received. DON stated the bed hold was obtained by the nurse on duty or the social worker, if available. A facility policy regarding the bed hold policy was requested, but was not received.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		10/15/20

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F 636	Continued From page 12 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,	F 636		

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F 636	Continued From page 13 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set (MDS) were completed for 2 of 6 residents (R14, R22) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2017, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, "include the completion of both the MDS and the CAA (care area assessment) process, as well as care planning." Further, the manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section M1030 "Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes... Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any venous or arterial ulcers are present".	F 636	To ensure all residents at the Pierz Villa have accurate comprehensive assessments of skin all MDS Section M were reviewed and/or modified to reflect accurate skin assessment. R14□s Admission MDS was modified on 9/22/2020 and R22□s Admission MDS was modified on 9/22/2020. R22 discharged from the facility on 9/17/2020. On 9/22/2020 skin interview form was designed for MDS coordinator to use to conduct interviews with team members on resident skin integrity. On 9/21/2020 MDS coordinator was educated in the importance of checking the Head to Toe skin inspection while completing section M of the MDS. Audits of comprehensive assessments MDS Section M will be conducted on all new admissions monthly x3 months or until resolved. Results will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020	

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Section M1040 "Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes... Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present".

R14's Admission comprehensive assessment dated 11/26/19, had a check mark in the box to indicate the presence of a rash on R14's left leg, which per family's report, had been there 30+ years.

R14's admission MDS, dated 12/2/2019, section M1030 had a 0 in the box to enter the total number of venous and arterial ulcers present. Further, M1040 had an "X" in the box for none of the above as the answer to other ulcers, wounds, and skin problems,

During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about the size of a quarter with a whitish scab and a drainage spot the size of a pin head on the sock. R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed.

During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed that she had completed R14's initial skin assessment and recalled a rash on the left shin.

During an interview on 8/20/20, at 11:07 a.m.

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MDS coordinator (RN-C) stated information to complete the MDS was gathered through the electronic health record, nurses notes, and wound documentation. RN-C confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission, until the day prior.

R22's admission MDS, dated 6/25/20, identified R22 was cognitively intact. The MDS further identified R22 was at risk for pressure ulcers/injuries. However, the MDS indicated R22 did not have any unhealed pressure ulcers.

During interview on 8/20/20, at 8:42 a.m. RN-A stated R22's skin was not intact and that R22 had wounds on his left great toe since admission.

During interview on 8/20/20, at 9:27 a.m. RN-B confirmed R22 had four wounds on his left great toe. RN-B further confirmed each of these areas were likely caused by pressure.

During interview on 8/20/20, at 12:31 p.m. RN-C verified R22's admission MDS did not indicate pressure ulcers. RN-C stated she was not aware of the wounds because they were not noted in the progress notes or admission assessments.

During interview on 8/20/20, at 12:37 p.m. DON confirmed R22's admission MDS failed to identify R22 had any pressure ulcers.

Review of the facility's policy, MDS-Minimum Data Set for Nursing Facility Residents' Assessment and Care Planning, dated 7/97, included input and assistance with completing the form shall be obtained from direct-care staff.

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F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful activities for 1 of 1 residents (R5), dependent on staff for activities. Findings include: R5's diagnoses include Alzheimer's disease, disorientation, unspecified confusion, dementia without behavioral disturbances, delusional disorders-paranoia, and unspecified mood disorder. R5's Care Area Assessment (CAA) dated 5/18/20, indicated a potential problem for cognitive loss/dementia related to diagnosis of dementia. R5's Activity Assessment dated 5/19/20, indicated participation strengths were social skills. Leisure interests were cards/other games, exercise/sports, music, reading/writing, watching TV, and talking or conversing. Focusing of programming indicated 1:1 activities, independent activities, outdoor activities, relaxation activities, social interaction activities, and other- ride in the	F 679	It is the goal and practice of Pierz Villa to provide activities that meet the variety of individual interests expressed by each resident through person-centered care. The expectation that staff will show competence with continued compliance of the following plan to provide and care plan the preferences of each resident with ongoing program to support residents in their choice of activities, both facilities sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. After review of the resident□s record, Activity Director interviewed resident R5 on August 19, 2020 to complete a reassessment of R5 interests. The care plan has been updated to reflect R5 preferences. Activity staff were updated on R5s preferences on August 19, 2020.	10/15/20

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F 679	Continued From page 17 country and bingo. Activity progress note indicated R5 was starting to play hallway bingo, one to one visits two times per week, and was given the daily newsletter along with the weekly Morrison County Record. R5's interests included reading the news and visiting with others. The Activity Assessment progress note further indicated to provide R5 with daily newsletter and to encourage activities of interest. R5's care plan, dated 8/17/20, indicated R5 had a variety of interests that included country music, cards, dice, bingo, outdoor activities and visiting with others. Goals for R5 included, R5 would participate in activities of his interest including playing cards, outdoor activity, dice, and bingo two to three times per week in the next three months. Interventions included adapt programs (bingo)/ provide in hallways, encourage resident to take part in activities of his interest, and provide one to one visits. R5's care plan also indicated he had an altered mood state related to diagnoses of dementia without behavioral disturbances, mood disorder and delusional disorder, and directed keeping R5 busy helped and that he loved activities. Goals for R5 included to involve in activities of interest. R5's Activity Participation Record from May through August of 2020 lacked evidence that R5 was offered activities of interest as indicated on R5's plan of care. Further, in May, R5 was offered bingo 11 days out of 31, June, was offered 13 days out of 30, July and August lacked evidence that R5 was offered bingo on any day. Resident Bingo list that was posted on bulletin boards of both south wings lacked evidence of R5 being invited to bingo on all seven days of the	F 679	Activity staff were educated on 9/23/2020 in the areas of accommodation of needs and benefits and best practices of activities programming. Charting education on activity logs were also reviewed with activities staff. Activity Staff were also educated on the importance of communicating to the Activities Director when refusal and participation is low so that Activities Director can reassess activities of interest with resident and update the plan of care. All resident□s records were reviewed during the week of September 14-18, 2020, to identify any other residents that have low participation and will reassess their activities of interest. Audits will be conducted weekly times four weeks on 4 residents, one of which will be R5 to ensure individuals interests are being honored, then monthly times 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee. Pierz Villa will be in compliance by October 15th, 2020.	

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F 679	Continued From page 18	F 679		

week evidenced by R5's name not being included on the list.

During observations on 8/18/20, at 12:55 p.m. through 1:46 p.m. R5 was sitting in his room, in his recliner, with TV off. Activity calendar indicated Bingo at 1:30 p.m.

During observations on 8/18/20, at 1:46 p.m. staff offered R5 to go outside and husk corn, but did not offer the choice between attending bingo or outdoor activity.

During observations on 8/18/20, at 2:20 p.m. through 4:30 p.m. R5 was sitting in his room, in his recliner, light off, and TV off. Activity calendar indicated dice/horse race at 4:15 p.m. Further, activity staff started activity at 4:12 p.m. and staff did not offer resident to participate in dice/horse race activity.

During interviews on 8/19/20, at 11:57 p.m. activity coordinator (AC) stated R5 enjoyed outdoor activities, cards, and Bingo. Further, AC stated R5 had been more quiet and had daily "pop- in" visits. AC confirmed R5 has not been getting daily newsletter due to her copier being broken and further stated she could use a different copier. AC confirmed R5 was not on Bingo invite list and stated she will assure R5 gets invited and involved more. Further, AC confirmed R5's activity logs were blank for Bingo in 8/20 and there were no marks of any refusals. AC stated that Bingo was offered in resident rooms everyday, but just recently started with group activities again. AC stated her expectation would be for staff to ask R5 if he would like to participate in the activities, especially those of R5's interests listed.

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F 679	Continued From page 19 During interviews on 8/19/20, at 12:35 p.m. DON stated her expectation of staff would be to offer R5 his favorite activities based off his preferences and staff should be following his care plan. Review of the facility Activity policy, dated 3/02, indicated the activity coordinator plans and organizes a program of activities for residents on a group level and for individuals. Residents shall be encouraged, but not forced, to participate in activities. Further, ambulatory resident may walk to and from activities or be assisted as needed. Non ambulatory residents will be encouraged to attend activities independently or will be assisted as needed.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a treatment was provided for a non-pressure skin wound, for 1 of 1 residents (R14), reviewed for non-pressure skin concerns. Findings include:	F 684	Pierz Villa strives to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents choice. R14 expired on 9/23/2020. On 8/19/2020 treatment and wound documentation was	10/15/20

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F 684	Continued From page 20 R14's quarterly Minimum Data Set (MDS), dated 5/27/20, indicated cognitive impairment, and R14 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. R14 had diagnoses of cancer, atrial fibrillation, heart failure, hypertension, cerebrovascular accident (CVA), and anxiety. R14's care plan, last revised 6/5/20, indicated R14 was no longer able to care for self at home and had low to no risk for pressure ulcers. Interventions included assist of one staff for dressing, daily skin inspection by nursing assistants, to apply compression stockings each morning and off at bedtime, and assistance for baths or shower on Friday. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area, approximately the size of a quarter, with a whitish scab and a drainage spot the size of a pin head on the sock. Further, R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed. During an interview on 8/19/20, at 7:13 a.m. trained medication aid (TMA)-C stated R14 was an early riser, mostly independent, and usually had her compression socks on prior to TMA entering R14's room. TMA-C stated she became aware of R14's wound a couple weeks prior and had reported it to registered nurse (RN)-A. During an interview on 8/19/20, at 12:33 p.m. RN-A stated awareness of a scabbed area on R14's left shin and stated there were no current orders for a dressing change or monitoring for the wound, other than a full skin assessment that was completed on bath days.	F 684	started on R14□s identified wound. On 9/18/2020 Head to Toe skin inspection policy and procedure was reviewed and revised. On 9/18/2020 the Pierz Villa Head to Toe Skin assessment was revised to include reveiwal from RN Case Manager on resident skin issues. Licensed Nurses will complete new head to toe skin inspections on residents to identify any new wounds and to capture current wounds being treated. On 9/21/2020 education was placed to the RN□s/LPN□s/TMA□s and NA/R□s via email on the importance of daily skin checks and weekly skin checks. Pierz Villa□s nursing team will be further educated on daily skins checks on 10/5/2020; 10/8/2020; 10/11/2020; 10/12/2020, and on weekly skin inspections on 10/7/2020; 10/8/2020 Audits of Head to Toe skin inspections will be conducted on 5 residents weekly for 1 month; then 3 other residents every other week for 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020.	

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F 684	Continued From page 21 During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed the R14's clinical record lacked evidence that R14 had a wound on her left shin, however, at 1:06 p.m. DON confirmed the presence of a wound on R14's left shin. DON stated it was her expectation that staff should have noted R14's wound during the weekly skin checks and would at least be doing a dressing change and monitoring. During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed she had completed R14's initial skin assessment and recalled a rash on the left shin. RN-B stated she was unaware of any current skin issues. During an interview on 8/20/20, at 11:07 a.m. MDS coordinator (RN-C) confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission, until the day prior. During an interview on 8/20/20 at 12:27 p.m. licensed practical nurse (LPN)-A stated she completed skin checks when residents were in the bathtub, but the bath aid would indicate if there were any concerns, and wounds were charted. LPN-A did not know if R14 had any wounds. Review of the facility policy, Wound Rounds, revised 1/15, stated resident wounds should be measured to show progress on a weekly basis to assure it continues to heal and to promote quality of life.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		10/15/20

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F 686	Continued From page 22 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately assess, monitor, implement interventions, and document skin conditions for a pressure ulcer for 1 of 2 residents (R22). Findings include: R22's admission Minimum Data Set (MDS) dated 6/25/20, identified R22 was able to make himself understood and his speech was clear. The MDS further identified R22 had diagnoses which included chronic obstructive pulmonary disorder (COPD), iron deficiency anemia and hypertension, had intact cognition, and required assistance from one staff for bed mobility, transfers, ambulation, dressing, toileting, personal hygiene, and bathing. R22's admission MDS failed to identify that R22 had a pressure ulcer/injury (bed sore). The MDS indicated a formal assessment instrument/tool was	F 686	R22 was discharged from facility on 9/17/2020 to home. R22 had measurements completed on 8/20/2020 and was placed on weekly wound rounds. Weekly wound rounds were completed until discharge with no identification of worsening of wound. To ensure that all residents at the Pierz Villa with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing all residents will have Head to Toe skin assessments completed by a licensed nurse to identify any new skin integrity issues. Upon resident skin inspections with any identifiable wound, the residents primary	

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F 686	Continued From page 23 completed and used to complete the MDS and that R22 was at risk for pressure ulcer/injury. R22's admission skin assessment, dated 6/19/20 failed to indicate a wound was noted by the assessing nurse upon admission. R22's skin assessment upon hospital return, dated 7/20/20, identified, "necrotic [dead tissue] area on Lt [left] grt [great] toe." R22's progress notes, dated 6/19/20-8/20/20, failed to identify the wound on R22's left toe, and failed to identify if R22's primary physician or if a nurse practitioner had been updated regarding the wound on R22's left great toe. R22's weekly skin checks failed to identify new or worsening skin concerns, including the area on R22's left great toe. R22's care plan, dated 6/22/20, and revised 8/3/20, indicated R22 was at low risk for pressure ulcers as evidenced by Braden Scale (used to determine risk for pressure ulcer/injury). Interventions included daily skin inspections by nursing assistants (NA), float heels off of bed, and turn and reposition every two hours. R22's treatment order, dated 7/20/20, included, "clean left great toe with NS [normal saline] pat dry, then swab with Betadine daily and allow to dry. Keep clean dry and intact." During interview on 8/17/20, at 5:09 p.m. R22 reported a black spot on the top of his left big toe. R22 reported the black spot was present when he admitted to this facility, "I don't know when it happened. I think it was before I came here." R22	F 686	physician will be notified via fax and resident wound will be documented and started on weekly wound rounds. Resident will continue with weekly wound rounds. Skin breakdown policy was reviewed and revised on 9/18/2020. Head to Toe Skin Assessment Policy was reviewed and revised on 9/18/2020. Wound Round policy was reviewed on 9/18/2020 with no changes noted. On 9/21/2020 RN□s and LPN□s were educated via email. Further education will take place on 10/5/2020; 10/7/2020; 10/8/2020; 10/11/2020; 10/12/2020. Audits of Head to Toe skin assessment will be conducted on all new admissions weekly for 1 month; then every other week for 2 months or until resolved. Results of audits will be shared and discussed with QA committee. Pierz Villa will be in compliance on 10/15/2020.	

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F 686	Continued From page 24	F 686		

further stated the areas were treated by facility staff on a daily basis.

During observation on 8/19/20, at 7:23 a.m. registered nurse (RN)-A completed treatment on R22's left great toe as ordered by his physician. Observation of the left great toe, revealed the following: four areas of eschar (area of dead tissue), one above toenail at top of toe that was smaller than a dime; one area to the right of toenail; one to the left of the toenail and one on the underside of the toe. There was no swelling or redness. R22 offered complaints of pain when area was touched and when swabbed with iodine, and reported pain as, "Not too bad, but I can feel it."

During interview on 8/20/20, at 8:42 a.m. RN-A stated the process at admission included a skin assessment by a registered nurse. If concerns with skin were found, then a nursing treatment was put in the computer for the area to be monitored. If size, shape, color needed to be documented in wound rounds, then it would be. RN-A stated, "[R22] skin is not intact, not his toe. He's had the black spot on his left toe since he admitted to this facility," and indicated not being sure what caused the area on his left great toe. RN-A further stated, R22 received a weekly skin check that was completed by a nurse. RN-A confirmed weekly skin checks failed to identify the wound on R22's left great toe. RN-A further confirmed there were no measurements of the wound on R22's left great toe, in the skin assessments or skin checks. RN-A stated she was not able to determine if the wound on R22's left great toe had improved or worsened since admission due the lack of documentation, including measurements. RN-A stated she had

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F 686	Continued From page 25	F 686		

been monitoring the wound since admission and thought it looked the same as it did when R22 admitted to the facility.

During interview on 8/20/20, at 9:10 a.m. RN-B stated the process for treatments performed on wounds that are not pressure related, are completed by either licensed practical nurse (LPN) or RN. If the nurse who completed the treatment had questions or concerns regarding the wound, they would talk with RN-B or update a nurse practitioner. RN-B reported the RN who completed the admission assessment would determine if the resident had a pressure ulcer and wound rounds were completed weekly for residents identified to have a pressure ulcer. RN-B stated she was one of the nurses assigned to complete wound rounds and stated she was not aware of the wound on R22's left great toe. RN-B further confirmed R22's medical record, including progress notes and assessments failed to identify a pressure ulcer.

During observation and interview on 8/20/20, at 9:27 a.m. RN-B assessed R22's left great toe. RN-B reported her findings as: necrotic area on tip of toe and on side. No redness. No signs or symptoms of infection. Areas around wounds were blanchable (when skin becomes white or pale when slight pressure is applied). RN-B measured two of the wounds and stated the following measurements: tip of toe-1.4 centimeters (cm) x 1.5 cm, no measurable depth, no drainage; underside of toe- 0.6 cm x 0.7 cm, no measurable depth, no drainage. RN-B stated the other two necrotic areas are similar in size to the second area she measured. RN-B assessed wound to be pressure related and unstageable (severity cannot be determined). R22 stated he

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F 686	Continued From page 26 had pain in the toe when it was touched, however, declined to see a physician when offered by RN-B. RN-B confirmed presence of pressure ulcer on R22's left great toe and indicated the wound should have been identified upon admission. RN-B stated R22's left great toe should have been monitored on weekly wound rounds, starting at time of admission. During interview on 8/20/20, at 10:11 a.m. director of nursing (DON) stated skin assessments were completed on the day of admission by the RN Case Manager and included a full head-to-toe skin assessment, and the nurse manager determined if noted skin concerns were related to pressure. DON stated weekly skin checks were completed by LPN's on the residents' bath day. The nurse manager completed weekly wound rounds for pressure ulcers. Documentation of pressure ulcers included measurements, length, width, and depth, presence of drainage, appearance of wound, including wound bed and staging (stage I-IV, depending on severity of wound). DON verified there was no documentation of R22's left great toe wound on his admission skin assessment. The facility's pressure ulcer policy was requested but not received.	F 686		
F 689 SS=G	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	F 689		9/24/20

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F 689	Continued From page 27 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 secure 1 of 1 residents (R21) with a safety belt while in the tub chair. This resulted in actual harm when R21 fell from the bath chair and sustained a nasal fracture and laceration to the bridge of his nose and required five stitches. Prior to this survey the facility had implemented corrective action on 3/17/20. The deficient practice is being issued as past non-compliance. Findings include: R21's quarterly Minimum Data Set (MDS) dated 6/18/20, identified R21 had severe cognitive impairment and had diagnoses which included Parkinson's disease and diabetes mellitus. The MDS indicated R21 was dependent with transfers and bathing tasks, and required extensive assistance with all other activities of daily living (ADLs). The MDS identified R21 had no falls since the prior assessment and identified R21's transfer balance was not steady and only able to stabilize with human assistance. R21's annual Care Area Assessment (CAA) dated 12/24/19, identified R21 had cognitive loss due to Parkinson's disease and required assist of two with bed mobility, transfers, toileting, and dressing. The CAA indicated R21 required assist of one with locomotion, personal hygiene and bathing. R21's care plan, revised 7/9/20, identified R21 had cognitive loss related to Parkinson's disease	F 689	Past noncompliance: no plan of correction required.	

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and required assist of two with a Hoyer (mechanical lift used to transfer immobile residents) to transfer. The care plan instructed staff to use two staff to transfer R21 to the tub chair and to use the safety belt on R21 when in the tub chair. The care plan identified R21 was at risk for falls due to limited mobility secondary to Parkinson's disease.

Review of R21's event report dated 3/12/20, indicated R21 fell face first out of the tub lift chair in his room due to staff not applying the safety belt. R21 developed a triangular shaped cut across his nose and a cut between his eyes. R21 was noted to be face down in a large pool of blood and staff turned him to his back due to the bleeding and R21 being unable to breathe properly. Staff applied pressure to stop the bleeding and called 911. R21 was transferred to the local hospital for treatment. The post fall summary of the event report identified R21 fell out of the chair due to staff not applying the safety belt. Education was immediately provided to the staff involved, signs posted and the rest of the staff were educated on the importance of using the safety belt.

Review of R21's progress notes from 3/12/20, to 8/19/20, revealed the following:

- 3/12/20, at 8:11 a.m. staff reported they needed assistance as R21 was bleeding everywhere. R21 had a large pool of blood next to him and staff were noted to be applying pressure to R21's nose to stop the bleeding from the V-shaped laceration present on R21's bridge of his nose. Additionally, R21 had a small laceration between his brows. R21's right cheek and eye swelled up and pupils were noted to be sluggish. R21 was assisted off

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the floor to the ambulance cot with the Hoyer lift and assistance of four staff.

- 3/12/20, at 8:55 a.m. R21 fell face first out of the tub chair and landed on his face and had a triangular shaped cut across his nose, a laceration between his eyes and a large pool of blood underneath his face. Two NA's were present in the room at the time of the fall. Staff held R21's neck and turned R21 onto his back due to the bleeding and inability for R21 to breathe properly. Staff applied pressure and a NA called the ambulance. Staff noted bruising starting to form to R21's knees. R21 was transferred via ambulance to the local hospital.

- 3/12/20, at 12:49 p.m. R21 returned from the hospital with orders of Doxycycline (an antibiotic) 100 mg. (milligrams) twice daily and a nasal spray two to three sprays twice daily for three days.

- 3/12/20, at 10:10 p.m. R21 had bruising and swelling under his left eye, his nose and on his forehead. The stitches present on R21's nose remained clean dry and intact. R21 remained in bed all shift, appeared weaker than usual and refused to eat supper.

- 3/13/20, at 1:43 a.m. R21 continued to have bruising and swelling under his left eye and stitches were noted to be clean dry and intact.

- 3/13/20, at 12:07 p.m. R21 was seen by medical doctor (MD) for follow-up after the fall.

- 3/13/20, at 6:43 p.m. bruising and swelling noted under R21's left eye and bruising noted to R21's forehead.

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- 3/14/20, at 12:02 p.m. swelling continued to be noted under both R21's eyes and nose. Dark purple bruising under R21's left eye remained and the stitches to R21's nose laceration were clean dry and intact.

- 3/15/20, at 1:20 a.m. slight bruising noted under R21's eyes and swelling remained to R21's bridge of his nose and under his eyes.

- 3/15/20, at 10:19 p.m. stitches remained intact and bruising remained under R21's right eye.

- 3/17/20, R21 had appointment with ear nose and throat (ENT) MD (medical doctor) and sutures were removed from R21's laceration and the nasal fracture was noted to be in good position with no surgery required.

Review of MD progress notes from 3/12/20, to 3/17/20, revealed the following:

- 3/12/20- emergency department (ED) progress notes indicated R21 presented to the ED after a fall. R21 was noted to have Parkinson's Disease, was on Coumadin (a blood thinner) and occasionally had falls. R21 fell face first, hit his nose and had significant blood noted from his nose. CT (computerized tomography) scan was completed of the head, facial bones and neck and revealed a comminuted fracture (A comminuted fracture is a break or splinter of the bone into more than two fragments. Since considerable force and energy is required to fragment bone, fractures of this degree occur after high-impact trauma) of the nasal bone with deviation to the right. R21 received five sutures to the laceration to the nose he obtained from the

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fall. R21 was sent back to the facility on antibiotics and a nasal spray with plans to follow-up with the ENT MD sometime in the next week.

- 3/13/20, family medicine progress note indicated R21 was seen for a follow-up ED (emergency department) visit. On 3/12/20, R21 fell and hit his face on the floor and sustained a displaced fracture of the nasal bone and a laceration to his nose. Plan to continue antibiotics, follow-up with ENT and to have sutures removed in five to seven days.

- 3/17/20, ENT progress note indicated R21's sutures were removed from the nasal laceration and the nasal fracture was in good position.

Review of the CT of the head results on 3/12/20, revealed a comminuted fracture of the nasal bone with mild deviation to the right.

Review of R21's MD current orders revealed R21 was on Coumadin 5 mg five days a week and received Coumadin 7.5 mg. two days a week.

During observation on 8/19/20, at 9:07 a.m. R21 was seated in his wheelchair while nursing assistant (NA)-A and NA-B applied the loops from the lift sling to the Hoyer lift. NA-A operated the Hoyer lift to lift R21 up out of wheelchair while NA-B guided R21 to the bed. NA-A lowered R21 down in the bed and with NA-B's assistance removed the sling from underneath R21 while rolling him back and forth in bed. NA-B removed R21's incontinence brief, provided peri cares and applied a fresh brief. NA-A removed R21's shoes, covered R21 with a blanket and clipped his call light to his bed within his reach. NA-A and NA-B

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removed their gloves and completed hand hygiene. R21 had non-skid strips next to his bed and in his bathroom.

On 8/19/20, at 9:14 a.m. NA-B stated R21 required total assistance with all cares and a Hoyer lift was used for transfers. NA-B stated R21 received a tub bath twice a week, indicated two staff transferred R21 onto the tub chair and stated staff were expected to apply the safety belt around R21's waist when he was in the chair to prevent falls. NA-B stated R21 did have a fall from the tub chair a few months ago and R21 required stitches to his nose.

On 8/19/20, at 10:41 a.m. NA-C stated she worked five days a week as the bath aid for the facility. NA-C stated R21 received a tub bath two days a week on Mondays and Thursdays and indicated he was totally dependent on staff for transfers onto the tub chair and for bathing tasks. NA-C stated it was an expectation the staff apply the safety belt to R21 when he was in the tub chair. NA-C stated she was aware R21 had a fall from the tub chair a few months back after staff had not applied the safety strap and he required a trip to the hospital as a result of the fall.

On 8/19/20, at 10:49 a.m. registered nurse case manager (RN)-A confirmed R21 had a fall from the tub chair a few months ago when staff had not applied the safety belt and "broke his nose." RN-A confirmed R21 was not able to hold himself up in the tub chair due to Parkinson's disease and indicated the safety belt should have been applied at all times. RN-A reviewed R21's electronic health record (EHR) and stated on 3/12/20, R21 had a nasal fracture and had stitches to the bridge of his nose as a result of the

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fall from the tub chair. RN-A stated all staff received education and signs were posted to remind staff to apply the safety belt when R21 and other residents were in the tub chair.

On 8/19/20, at 11:27 a.m. NA-D stated R21 required total assistance from staff with most ADLs and he tended to lean forward when up in the tub chair. NA-D stated on 3/12/20, she was wheeling R21 in the tub chair to the doorway of his room to bring him to the tub room for his bath when R21 fell forward from the tub chair, landed on his face and started to bleed. NA-D confirmed staff had not applied the safety belt to R21 prior to his fall. NA-D stated the nurse was notified, provided first aid to R21 and R21 was sent to the hospital for treatment. NA-D stated R21 received a cut from the fall and indicated she received immediate education on the use of the safety belt when R21 and other residents were up in the tub chair.

On 8/19/20, at 11:35 a.m. director of nursing (DON) stated it was expected staff applied the safety belt for all tub chair transfers. DON confirmed R21 had a fall on 3/12/20, from the tub chair due to staff not applying the safety belt to R21. DON confirmed R21 was sent to the ED and was diagnosed with a nasal fracture and received five stitches to the laceration present on the bridge of his nose. DON stated immediate education occurred to the staff involved in the incident and reminder signs were placed in both tub rooms of the need to use the safety belt. DON stated all nursing staff were educated on the use of the safety belt beginning that same morning and was completed by the time the incident report was closed on 3/17/20. DON stated R21's care plan was updated on 3/17/20, to instruct staff to

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apply the safety belt as soon as R21 was up in the tub chair. DON stated audits of the use of safety belts had been completed and no further issues were identified.

Review of the manufacturer's instructions titled System Preparation (Before Transferring of Lifting), undated, instructed staff to route the belt through the belt loops of the chair frame prior to placing the resident into the chair. After the resident is transferred to the chair, staff were instructed to bring the seat belt around the resident to be connected.

Review of facility policy, Baths, dated 7/01, instructed staff to assist resident into the tub chair and secure the safety straps.

Review of the employee files revealed both NA's that assisted R21 on the day of the fall had been trained in the use of the safety belt for tub baths upon hire.

The past non-compliance that began on 3/12/20, was verified during the 8/20/20, onsite visit and was corrected by the facility on 3/17/20. The verification of corrective action was confirmed by interview with a variety of nursing staff, residents and observation of residents who received tub baths, in addition to documentation of education provided to the nursing staff. On 3/12/20, immediate education was provided to the staff involved. R21's care plan was revised and education was completed for the majority of the remaining nursing staff by 3/17/20. Additionally, reminder signs were posted in both of the tub rooms in the facility and audits were completed to ensure staff compliance with the use of the safety belt.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 690	Pierz Villa strives to ensure that residents	10/15/20

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F 690	Continued From page 36 review, the facility failed to ensure proper placement and storage of catheter drainage bag was provided, in a manner to prevent potential for infections for 1 of 1 resident (R24), reviewed for catheter care. Findings include: R24's admission Minimum Data Set (MDS), dated 6/26/20, identified R24 had moderate cognitive impairment and required assistance from one staff for bed mobility, transfers, ambulation, dressing, personal hygiene, bathing, and toilet use. In addition, R24's MDS identified diagnoses included hypertension, constipation, benign prostatic hyperplasia (enlargement of the prostate gland), and urine retention, and had an indwelling catheter. R24's care plan, dated 7/2/20, directed catheter cares twice daily and as needed, to change the catheter as ordered by the physician and according to Centers for Disease Control recommendations, to change the drainage bag weekly, to cover the urinary collection bag, and to keep the drainage bag below the level of the bladder. Review of R24's progress notes did not indicate R24 was non-compliant with placement of catheter collection/drainage bag. During observation and interview on 8/17/20, at 4:47 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was covered inside another bag and was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. R24	F 690	who are incontinent of bladder receives appropriate treatment to prevent urinary tract infection and to restore continence to the extent possible. Pierz Villa Team members were educated on the placement of a catheter bags via an email on 8/20/2020 and again on 8/24/2020. The policy and procedure titled Indwelling Catheter Care was reviewed on 9/16/2020, with no changes made to the policy. Further education will be provided to the Pierz Villa nursing team on 10/5/2020 through 10/12/2020. Catheter bag placement audits will be conducted on R24 and all new admissions with catheter or residents that require a catheter 3 times weekly on varying shifts for 1 month; then 2x weekly on varying shifts for 2 months. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020	

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stated, "They were looking at my chair to find a place to hang it under the chair but they didn't find anything that would work," and stated the collection bag was always hanging where it was noted at time of this observation.

During observation on 8/18/20, at 12:49 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. The collection bag was covered by a bandana tied to the wheelchair.

During observation on 8/18/20, at 12:55 p.m. nursing assistant (NA)-E emptied R24's urine collection bag. After the bag was emptied, NA-E placed the collection bag so it hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. NA-E covered the collection bag with the bandana.

During observation on 8/19/20, at 7:52 a.m. R24 was seated in his wheelchair in the dining room. The urine collection bag hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was covered with a bandana. The catheter tubing was noted to come out of bottom of R24's pant leg then extend up to the top of the urine collection bag.

During observation on 8/19/20, at 8:59 a.m. R24 was ambulating in the hallway with staff. Urine collection bag was stored in a bag attached to the cross bars under R24's wheelchair.

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During interview on 8/19/20, at 9:09 a.m. R24 stated he didn't know why the urine collection bag was hanging under his chair. "They said they moved it because they don't like to see it on the side of the chair."

During observation on 8/19/20, at 11:39 a.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was not covered.

During interview on 8/19/20, at 11:42 a.m. NA-B stated she wasn't sure how the urine collection bag got placed on the side of his wheelchair. "It's supposed to be under his chair."

During interview on 8/19/20, at 11:47 a.m. NA-D stated R24 was mostly independent with cares, except catheter care, perineal care (cleaning the private areas), and cleaning R24's underarms. NA-D further stated she was just in R24's room and put the urine collection bag in the storage bag hanging from the cross bars under the wheelchair. "It is supposed to be under his chair."

During interview on 8/20/20, at 9:57 a.m. registered nurse (RN)-A stated, "I try to encourage him to keep it [urine collection bag] below his wheelchair. He always puts it back up on the armrest because it is where he likes it. I try to explain it drains better." RN-A further stated, staff would be putting it back under R24's wheelchair or educating R24 when they notice it is on the side of R24's wheelchair or they should tell her about it and she would take care of it.

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F 690	Continued From page 39 RN-A confirmed, if the urine collection bag is not stored below the level of the bladder, the urine will not drain and may result in urinary tract infections. RN-A confirmed further that staff should be making attempts to put the urine drainage bag under R24's wheelchair so it can drain properly. During interview on 8/20/20 at 10:03 a.m. director of nursing (DON) stated the expectation is that the urine collection bag is hung from the bed frame, below the level of bladder, when R24 is in bed and below the seat of the wheelchair, in a bag, to ensure it is below the level of the bladder, for gravity flow. DON confirmed, if the urine collection bag is not kept below the level of the bladder, it may cause the urine to back flow into the bladder which could cause an infection. DON stated further, "It [urine collection bag] should be under the chair. Staff should follow the care plan." DON confirmed, R24's care plan stated to keep drainage bag below level of bladder. DON stated she would expect staff to educate R24 with reason for urine collection bag to go under the wheelchair when it noted to be on the side of the wheelchair. Review of the facility policy, Catheter. Care of Indwelling. Suprapubic, dated 12/95 indicated, "Observe drainage bag position; must never touch the floor and always kept below the level of the bladder."	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		10/15/20

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 08/20/2020

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PIERZ VILLA INC	119 FAUST STREET SOUTHEAST PIERZ, MN 56364

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F 761	Continued From page 40 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was labeled properly for 1 of 1 resident (R14) reviewed for medications at the bedside. In addition, the facility failed to ensure medications available for use in the South medication cart, was appropriately labeled with an opened date for 1 of 1 residents (R10) reviewed for medication storage. Findings include: R14's quarterly Minimum Data Set (MDS) dated 5/27/20, indicated moderate cognitive impairment and had diagnoses including cancer, atrial	F 761	Pierz Villa strives to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to keys. R14 expired on 9/23/2020. On 8/19/2020 ointment was removed from R14□s room by DON and resident was educated by DON that the facility needs to have a physician order for the medication. DON also educated resident that if she wishes to keep the ointment in her room she, a RN needs to do an assessment. DON on 8/19/2020 also educated resident that if	

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F 761	Continued From page 41 fibrilation, heart failure, hypertension, cerebrovascular accident (CVA), and anxiety. R14's physician orders printed on 8/19/20 included triamcinolone acetonide cream 0.5% (used to treat skin inflammation), with directions to apply thin layer to affected areas(s) twice daily as needed. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about the size of a quarter with a whitish scab and a drainage spot on the sock that was about the size of a pinhead. R14 produced a tube of ointment which she stated she routinely applied. The tube lacked a prescription label. During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed R14 had a wound on her left shin and possessed a tube of ointment which lacked an order and appropriate labeling. DON presented the ointment tube to registered nurse (RN)-A, who also denied awareness of the ointment. DON stated R14 lacked an order, appropriate labeling and assessment for self administration. DON removed the ointment from R14's possession until further evaluation could be completed. Review of the facility's Medication Labeling policy, revised 6/2018, included, "F. Over-the-counter meds brought in by residents may be used if in the original unopened container-labeled as below: -Resident's Name -Date received -Direction for use from the doctor." R10's quarterly MDS dated 5/24/20, R10's	F 761	medication is brought in by family in needs to be brought to the nurse□s station until we can get an order. Resident voiced understanding of facility procedure. On 9/18/2020, DON educated resident Next of Kin in regards to the findings during this survey. DON educated NOK that if a family member brings medication into the facility for the resident it needs to be taken directly to the nurses station as we need to get it labeled, have an MD order and complete an assessment if the resident wishes to keep the medication in their room. NOK was in agreement with plan. On 9/21/2020 Pierz Villa updated family in weekly update of the procedure when bringing in medications to residents. On 9/21/2020 an email was sent to all Pierz Villa team members to scan the room for any medications sitting out in resident rooms while they are in the rooms. Further education will be provide to all Pierz Villa team members on 10/5/2020; 10/7/2020; 10/8/2020; 10/11/2020; 10/12/2020. Auditing of resident rooms for medications will be conducted 5 resident rooms 1 time weekly for 1 month; every other week for 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020. Medication Labeling	

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F 761	Continued From page 42 diagnosis included diabetes mellitus, disease of the nasal cavity and sinuses, dry eye syndrome. R10's physician orders include Latanoprost ophthalmic (eye) drops, instill one drop into left eye every evening and Fluticasone 50 mcg, instill one spray into each nostril daily. During inspection of the South medication cart on 8/17/20, at 5:30 p.m. with registered nurse (RN) -B, R10's Latanprost ophthalmic (eye) drops were opened, in the cart. There was no opened date on the medication bottle or the prescription bottle the medication was stored in. According to the pharmacy labe on the Latanoprost, this medication was filled by the pharmacy on 7/22/20. R10's Fluticasone, a nasal spray, had an opened date on the medication bottle as well as on the box the medication is stored it. The opened date, handwritten on the medication package and medication bottle, was 4/6. During interview on 8/17/20, at time of medication cart inspection, RN-B stated medications such as ophthalmic drops and nasal sprays were to be labeled with the opened date. RN-B further stated Fluticasone should have been discarded six weeks after the medication was opened. RN-B confirmed the ophthalmic drops were opened but not labeled and the Fluticasone was labeled with an opened date, but was past the timeline for safe administration of 6 weeks. During interview on 8/19/20, at 2:13 p.m. director of nursing (DON) stated ophthalmic drops and nasal sprays are expected to be dated with opened date, when the medication is opened. DON further stated, "They should be checking their med carts and expiration dates."	F 761	Pierz Villa strives to ensure drugs and biologicals use in our facility are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and expiration when applicable On 9/17/2020 upon review of F761 it was noted that Fluticasone Nasal Spray does not have a Shortened Expiration date per the Medication Expiration after Opening Table. DON consulted with pharmacist consultant and reviewal of the manufacturer recommendation pamphlet it was identified that Fluticasone Nasal Spray expiration date is the manufacturers date as pre-labeled on the bottle. Pierz Villa will audit all nasal sprays for open and expiration date per the Medication Expiration after Opening Table utilized by the facility. On 8/24/2020 Pierz Villa implemented labels with open date/expiration date to be placed on medications with shortened expiration dates. The policy and procedure for medication labeling was reviewed and revised on 9/17/2020 to include the list of Medication Expiration after Opening. On 9/17/2020 the Medication Expiration after Opening list was placed on the north and south medication carts and nurse stations for referencing. On 9/17/2020 DON checked resident eye drops and nasal spray for open dates and expiration dates with 100% compliance found. RN□s/LPN□s	

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F 761	Continued From page 43 Review of the facility policy, Medication Labeling, dated 6/18, did not address the need to date ophthalmic drops or nasal sprays with opened date. Review of the facility policy, Eye Drops, dated 9/18, indicated Latanoprost must be dated upon opening and needed to be discarded six weeks after opening. A request for the facility policy regarding nasal sprays was requested, but was not received.	F 761	and TMA□s were educated via email on 9/18/2020. On 9/18/2020 a system was established to check medication carts weekly for expiration dates. Further education will be provided to the Pierz Villa Nursing Team on 10/5/2020; 10/7/2020; 10/8/2020; 10/11/2020; 10/12/2020. Audits of Labeling eye drops and nasal sprays with open dates and expiration date will be conducted on all residents including R10 weekly for 1 months; then every other week for 2 months or until resolved. Results of audits will be reviewed and discussed with QA committee until resolved. Pierz Villa will be in compliance on 10/15/2020	

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2020**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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) 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 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 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.	K 000		

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

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 The facility has a capacity of 50 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are MET:	K 000		

Electronically delivered
September 14, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: EQ9S11

Dear Administrator:

The above facility was surveyed on August 17, 2020 through August 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 _____	C 08/20/2020

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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 August 17, 2020 through August 20, 2020, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 In addition, complaint investigations were also completed at the time of the licensing survey. The following complaint was found to be substantiated: H5286030C- No state correction order issued. H5286028C-No state correction order issued. The following complaints were found unsubstantiated: H5286029C H5286027C H5286031C 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. 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. 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.	2 000		

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2 000	Continued From page 2 The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The	2 540		10/15/20

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2 540	Continued From page 3 comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set (MDS) were completed for 2 of 6 residents (R14, R22) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2017, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, "include the completion of both the MDS and the CAA (care area assessment) process, as well as care planning." Further, the manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows:	2 540	Corrected	

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2 540	Continued From page 4 Section M1030 "Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes... Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any venous or arterial ulcers are present". Section M1040 "Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes... Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present". R14's Admission comprehensive assessment dated 11/26/19, had a check mark in the box to indicate the presence of a rash on R14's left leg, which per family's report, had been there 30+ years. R14's admission MDS, dated 12/2/2019, section M1030 had a 0 in the box to enter the total number of venous and arterial ulcers present. Further, M1040 had an "X" in the box for none of the above as the answer to other ulcers, wounds, and skin problems, During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about	2 540		

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2 540	Continued From page 5	2 540		

the size of a quarter with a whitish scab and a drainage spot the size of a pin head on the sock. R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed.

During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed that she had completed R14's initial skin assessment and recalled a rash on the left shin.

During an interview on 8/20/20, at 11:07 a.m. MDS coordinator (RN-C) stated information to complete the MDS was gathered through the electronic health record, nurses notes, and wound documentation. RN-C confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission, until the day prior.

R22's admission MDS, dated 6/25/20, identified R22 was cognitively intact. The MDS further identified R22 was at risk for pressure ulcers/injuries. However, the MDS indicated R22 did not have any unhealed pressure ulcers.

During interview on 8/20/20, at 8:42 a.m. RN-A stated R22's skin was not intact and that R22 had wounds on his left great toe since admission.

During interview on 8/20/20, at 9:27 a.m. RN-B confirmed R22 had four wounds on his left great toe. RN-B further confirmed each of these areas were likely caused by pressure.

During interview on 8/20/20, at 12:31 p.m. RN-C verified R22's admission MDS did not indicate pressure ulcers. RN-C stated she was not aware of the wounds because they were not noted in the

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2 540	Continued From page 6 progress notes or admission assessments. During interview on 8/20/20, at 12:37 p.m. DON confirmed R22's admission MDS failed to identify R22 had any pressure ulcers. Review of the facility's policy, MDS-Minimum Data Set for Nursing Facility Residents' Assessment and Care Planning, dated 7/97, included input and assistance with completing the form shall be obtained from direct-care staff. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure staff implement interventions for skin assessments, monitoring of skin concerns. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
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	2 830		10/15/20

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2 830	Continued From page 7 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 a treatment was provided for a non-pressure skin wound, for 1 of 1 residents (R14), reviewed for non-pressure skin concerns and failed to ensure proper placement and storage of catheter drainage bag was provided, in a manner to prevent potential for infections for 1 of 1 resident (R24), reviewed for catheter care. Findings include: R14's quarterly Minimum Data Set (MDS), dated 5/27/20, indicated cognitive impairment, and R14 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. R14 had diagnoses of cancer, atrial fibrillation, heart failure, hypertension, cerebrovascular accident (CVA), and anxiety. R14's care plan, last revised 6/5/20, indicated R14 was no longer able to care for self at home and had low to no risk for pressure ulcers. Interventions included assist of one staff for dressing, daily skin inspection by nursing assistants, to apply compression stockings each morning and off at bedtime, and assistance for baths or shower on Friday. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area, approximately the size of a quarter, with a whitish scab and a drainage spot the size of a pin head	2 830	Corrected	

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2 830	Continued From page 8	2 830		

on the sock. Further, R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed.

During an interview on 8/19/20, at 7:13 a.m. trained medication aid (TMA)-C stated R14 was an early riser, mostly independent, and usually had her compression socks on prior to TMA entering R14's room. TMA-C stated she became aware of R14's wound a couple weeks prior and had reported it to registered nurse (RN)-A.

During an interview on 8/19/20, at 12:33 p.m. RN-A stated awareness of a scabbed area on R14's left shin and stated there were no current orders for a dressing change or monitoring for the wound, other than a full skin assessment that was completed on bath days.

During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed the R14's clinical record lacked evidence that R14 had a wound on her left shin, however, at 1:06 p.m. DON confirmed the presence of a wound on R14's left shin. DON stated it was her expectation that staff should have noted R14's wound during the weekly skin checks and would at least be doing a dressing change and monitoring.

During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed she had completed R14's initial skin assessment and recalled a rash on the left shin. RN-B stated she was unaware of any current skin issues.

During an interview on 8/20/20, at 11:07 a.m. MDS coordinator (RN-C) confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission,

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2 830	Continued From page 9 until the day prior. During an interview on 8/20/20 at 12:27 p.m. licensed practical nurse (LPN)-A stated she completed skin checks when residents were in the bathtub, but the bath aid would indicate if there were any concerns, and wounds were charted. LPN-A did not know if R14 had any wounds. Review of the facility policy, Wound Rounds, revised 1/15, stated resident wounds should be measured to show progress on a weekly basis to assure it continues to heal and to promote quality of life. Based on observation, interview, and document review, the facility failed to ensure proper placement and storage of catheter drainage bag was provided, in a manner to prevent potential for infections for 1 of 1 resident (R24), reviewed for catheter care. Findings include: R24's admission Minimum Data Set (MDS), dated 6/26/20, identified R24 had moderate cognitive impairment and required assistance from one staff for bed mobility, transfers, ambulation, dressing, personal hygiene, bathing, and toilet use. In addition, R24's MDS identified diagnoses included hypertension, constipation, benign prostatic hyperplasia (enlargement of the prostate gland), and urine retention, and had an indwelling catheter. R24's care plan, dated 7/2/20, directed catheter cares twice daily and as needed, to change the catheter as ordered by the physician and according to Centers for Disease Control	2 830		

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2 830	Continued From page 10 recommendations, to change the drainage bag weekly, to cover the urinary collection bag, and to keep the drainage bag below the level of the bladder. Review of R24's progress notes did not indicate R24 was non-compliant with placement of catheter collection/drainage bag. During observation and interview on 8/17/20, at 4:47 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was covered inside another bag and was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. R24 stated, "They were looking at my chair to find a place to hang it under the chair but they didn't find anything that would work," and stated the collection bag was always hanging where it was noted at time of this observation. During observation on 8/18/20, at 12:49 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. The collection bag was covered by a bandana tied to the wheelchair. During observation on 8/18/20, at 12:55 p.m. nursing assistant (NA)-E emptied R24's urine collection bag. After the bag was emptied, NA-E placed the collection bag so it hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. NA-E covered the collection bag with the bandana.	2 830		

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2 830	Continued From page 11 During observation on 8/19/20, at 7:52 a.m. R24 was seated in his wheelchair in the dining room. The urine collection bag hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was covered with a bandana. The catheter tubing was noted to come out of bottom of R24's pant leg then extend up to the top of the urine collection bag. During observation on 8/19/20, at 8:59 a.m. R24 was ambulating in the hallway with staff. Urine collection bag was stored in a bag attached to the cross bars under R24's wheelchair. During interview on 8/19/20, at 9:09 a.m. R24 stated he didn't know why the urine collection bag was hanging under his chair. "They said they moved it because they don't like to see it on the side of the chair." During observation on 8/19/20, at 11:39 a.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was not covered. During interview on 8/19/20, at 11:42 a.m. NA-B stated she wasn't sure how the urine collection bag got placed on the side of his wheelchair. "It's supposed to be under his chair." During interview on 8/19/20, at 11:47 a.m. NA-D stated R24 was mostly independent with cares, except catheter care, perineal care (cleaning the private areas), and cleaning R24's underarms. NA-D further stated she was just in R24's room	2 830		

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2 830	Continued From page 12 and put the urine collection bag in the storage bag hanging from the cross bars under the wheelchair. "It is supposed to be under his chair." During interview on 8/20/20, at 9:57 a.m. registered nurse (RN)-A stated, "I try to encourage him to keep it [urine collection bag] below his wheelchair. He always puts it back up on the armrest because it is where he likes it. I try to explain it drains better." RN-A further stated, staff would be putting it back under R24's wheelchair or educating R24 when they notice it is on the side of R24's wheelchair or they should tell her about it and she would take care of it. RN-A confirmed, if the urine collection bag is not stored below the level of the bladder, the urine will not drain and may result in urinary tract infections. RN-A confirmed further that staff should be making attempts to put the urine drainage bag under R24's wheelchair so it can drain properly. During interview on 8/20/20 at 10:03 a.m. director of nursing (DON) stated the expectation is that the urine collection bag is hung from the bed frame, below the level of bladder, when R24 is in bed and below the seat of the wheelchair, in a bag, to ensure it is below the level of the bladder, for gravity flow. DON confirmed, if the urine collection bag is not kept below the level of the bladder, it may cause the urine to back flow into the bladder which could cause an infection. DON stated further, "It [urine collection bag] should be under the chair. Staff should follow the care plan." DON confirmed, R24's care plan stated to keep drainage bag below level of bladder. DON stated she would expect staff to educate R24 with reason for urine collection bag to go under the wheelchair when it noted to be on the side of the wheelchair.	2 830		

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2 830	Continued From page 13 Review of the facility policy, Catheter. Care of Indwelling. Suprapubic, dated 12/95 indicated, "Observe drainage bag position; must never touch the floor and always kept below the level of the bladder." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions and positioning and on proper catheter drainage bag placement. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care related to skin conditions as well as catheter drainage bag placement. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/15/20

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2 900	Continued From page 14 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately assess, monitor, implement interventions, and document skin conditions for a pressure ulcer for 1 of 2 residents (R22). Findings include: R22's admission Minimum Data Set (MDS) dated 6/25/20, identified R22 was able to make himself understood and his speech was clear. The MDS further identified R22 had diagnoses which included chronic obstructive pulmonary disorder (COPD), iron deficiency anemia and hypertension, had intact cognition, and required assistance from one staff for bed mobility, transfers, ambulation, dressing, toileting, personal hygiene, and bathing. R22's admission MDS failed to identify that R22 had a pressure ulcer/injury (bed sore). The MDS indicated a formal assessment instrument/tool was completed and used to complete the MDS and that R22 was at risk for pressure ulcer/injury. R22's admission skin assessment, dated 6/19/20 failed to indicate a wound was noted by the assessing nurse upon admission. R22's skin assessment upon hospital return, dated 7/20/20, identified, "necrotic [dead tissue] area on Lt [left] grt [great] toe."	2 900	Corrected	

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2 900	Continued From page 15 R22's progress notes, dated 6/19/20-8/20/20, failed to identify the wound on R22's left toe, and failed to identify if R22's primary physician or if a nurse practitioner had been updated regarding the wound on R22's left great toe. R22's weekly skin checks failed to identify new or worsening skin concerns, including the area on R22's left great toe. R22's care plan, dated 6/22/20, and revised 8/3/20, indicated R22 was at low risk for pressure ulcers as evidenced by Braden Scale (used to determine risk for pressure ulcer/injury). Interventions included daily skin inspections by nursing assistants (NA), float heels off of bed, and turn and reposition every two hours. R22's treatment order, dated 7/20/20, included, "clean left great toe with NS [normal saline] pat dry, then swab with Betadine daily and allow to dry. Keep clean dry and intact." During interview on 8/17/20, at 5:09 p.m. R22 reported a black spot on the top of his left big toe. R22 reported the black spot was present when he admitted to this facility, "I don't know when it happened. I think it was before I came here." R22 further stated the areas were treated by facility staff on a daily basis. During observation on 8/19/20, at 7:23 a.m. registered nurse (RN)-A completed treatment on R22's left great toe as ordered by his physician. Observation of the left great toe, revealed the following: four areas of eschar (area of dead tissue), one above toenail at top of toe that was smaller than a dime; one area to the right of toenail; one to the left of the toenail and one on the underside of the toe. There was no swelling	2 900		

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or redness. R22 offered complaints of pain when area was touched and when swabbed with iodine, and reported pain as, "Not too bad, but I can feel it."

During interview on 8/20/20, at 8:42 a.m. RN-A stated the process at admission included a skin assessment by a registered nurse. If concerns with skin were found, then a nursing treatment was put in the computer for the area to be monitored. If size, shape, color needed to be documented in wound rounds, then it would be. RN-A stated, "[R22] skin is not intact, not his toe. He's had the black spot on his left toe since he admitted to this facility," and indicated not being sure what caused the area on his left great toe. RN-A further stated, R22 received a weekly skin check that was completed by a nurse. RN-A confirmed weekly skin checks failed to identify the wound on R22's left great toe. RN-A further confirmed there were no measurements of the wound on R22's left great toe, in the skin assessments or skin checks. RN-A stated she was not able to determine if the wound on R22's left great toe had improved or worsened since admission due the lack of documentation, including measurements. RN-A stated she had been monitoring the wound since admission and thought it looked the same as it did when R22 admitted to the facility.

During interview on 8/20/20, at 9:10 a.m. RN-B stated the process for treatments performed on wounds that are not pressure related, are completed by either licensed practical nurse (LPN) or RN. If the nurse who completed the treatment had questions or concerns regarding the wound, they would talk with RN-B or update a nurse practitioner. RN-B reported the RN who completed the admission assessment would

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2 900	Continued From page 17	2 900		

determine if the resident had a pressure ulcer and wound rounds were completed weekly for residents identified to have a pressure ulcer. RN-B stated she was one of the nurses assigned to complete wound rounds and stated she was not aware of the wound on R22's left great toe. RN-B further confirmed R22's medical record, including progress notes and assessments failed to identify a pressure ulcer.

During observation and interview on 8/20/20, at 9:27 a.m. RN-B assessed R22's left great toe. RN-B reported her findings as: necrotic area on tip of toe and on side. No redness. No signs or symptoms of infection. Areas around wounds were blanchable (when skin becomes white or pale when slight pressure is applied). RN-B measured two of the wounds and stated the following measurements: tip of toe-1.4 centimeters (cm) x 1.5 cm, no measurable depth, no drainage; underside of toe- 0.6 cm x 0.7 cm, no measurable depth, no drainage. RN-B stated the other two necrotic areas are similar in size to the second area she measured. RN-B assessed wound to be pressure related and unstageable (severity cannot be determined). R22 stated he had pain in the toe when it was touched, however, declined to see a physician when offered by RN-B. RN-B confirmed presence of pressure ulcer on R22's left great toe and indicated the wound should have been identified upon admission. RN-B stated R22's left great toe should have been monitored on weekly wound rounds, starting at time of admission.

During interview on 8/20/20, at 10:11 a.m. director of nursing (DON) stated skin assessments were completed on the day of admission by the RN Case Manager and included a full head-to-toe skin assessment, and the nurse

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2 900	Continued From page 18 manager determined if noted skin concerns were related to pressure. DON stated weekly skin checks were completed by LPN's on the residents' bath day. The nurse manager completed weekly wound rounds for pressure ulcers. Documentation of pressure ulcers included measurements, length, width, and depth, presence of drainage, appearance of wound, including wound bed and staging (stage I-IV, depending on severity of wound). DON verified there was no documentation of R22's left great toe wound on his admission skin assessment. The facility's pressure ulcer policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, provide training to nursing staff and could conduct audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing	21435		10/15/20

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21435	Continued From page 19 home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful activities for 1 of 1 residents (R5), dependent on staff for activities. Findings include: R5's diagnoses include Alzheimer's disease, disorientation, unspecified confusion, dementia without behavioral disturbances, delusional disorders-paranoia, and unspecified mood disorder. R5's Care Area Assessment (CAA) dated 5/18/20, indicated a potential problem for cognitive loss/dementia related to diagnosis of dementia. R5's Activity Assessment dated 5/19/20, indicated participation strengths were social skills. Leisure interests were cards/other games, exercise/sports, music, reading/writing, watching TV, and talking or conversing. Focusing of programming indicated 1:1 activities, independent activities, outdoor activities, relaxation activities, social interaction activities, and other- ride in the	21435	Corrected	

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21435	Continued From page 20	21435		

country and bingo. Activity progress note indicated R5 was starting to play hallway bingo, one to one visits two times per week, and was given the daily newsletter along with the weekly Morrison County Record. R5's interests included reading the news and visiting with others. The Activity Assessment progress note further indicated to provide R5 with daily newsletter and to encourage activities of interest.

R5's care plan, dated 8/17/20, indicated R5 had a variety of interests that included country music, cards, dice, bingo, outdoor activities and visiting with others. Goals for R5 included, R5 would participate in activities of his interest including playing cards, outdoor activity, dice, and bingo two to three times per week in the next three months. Interventions included adapt programs (bingo)/ provide in hallways, encourage resident to take part in activities of his interest, and provide one to one visits. R5's care plan also indicated he had an altered mood state related to diagnoses of dementia without behavioral disturbances, mood disorder and delusional disorder, and directed keeping R5 busy helped and that he loved activities. Goals for R5 included to involve in activities of interest.

R5's Activity Participation Record from May through August of 2020 lacked evidence that R5 was offered activities of interest as indicated on R5's plan of care. Further, in May, R5 was offered bingo 11 days out of 31, June, was offered 13 days out of 30, July and August lacked evidence that R5 was offered bingo on any day.

Resident Bingo list that was posted on bulletin boards of both south wings lacked evidence of R5 being invited to bingo on all seven days of the week evidenced by R5's name not being included

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21435	Continued From page 21 on the list. During observations on 8/18/20, at 12:55 p.m. through 1:46 p.m. R5 was sitting in his room, in his recliner, with TV off. Activity calendar indicated Bingo at 1:30 p.m. During observations on 8/18/20, at 1:46 p.m. staff offered R5 to go outside and husk corn, but did not offer the choice between attending bingo or outdoor activity. During observations on 8/18/20, at 2:20 p.m. through 4:30 p.m. R5 was sitting in his room, in his recliner, light off, and TV off. Activity calendar indicated dice/horse race at 4:15 p.m. Further, activity staff started activity at 4:12 p.m. and staff did not offer resident to participate in dice/horse race activity. During interviews on 8/19/20, at 11:57 p.m. activity coordinator (AC) stated R5 enjoyed outdoor activities, cards, and Bingo. Further, AC stated R5 had been more quiet and had daily "pop- in" visits. AC confirmed R5 has not been getting daily newsletter due to her copier being broken and further stated she could use a different copier. AC confirmed R5 was not on Bingo invite list and stated she will assure R5 gets invited and involved more. Further, AC confirmed R5's activity logs were blank for Bingo in 8/20 and there were no marks of any refusals. AC stated that Bingo was offered in resident rooms everyday, but just recently started with group activities again. AC stated her expectation would be for staff to ask R5 if he would like to participate in the activities, especially those of R5's interests listed. During interviews on 8/19/20, at 12:35 p.m. DON	21435		

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21435	Continued From page 22 stated her expectation of staff would be to offer R5 his favorite activities based off his preferences and staff should be following his care plan. Review of the facility Activity policy, dated 3/02, indicated the activity coordinator plans and organizes a program of activities for residents on a group level and for individuals. Residents shall be encouraged, but not forced, to participate in activities. Further, ambulatory resident may walk to and from activities or be assisted as needed. Non ambulatory residents will be encouraged to attend activities independently or will be assisted as needed. SUGGESTED METHOD OF CORRECTION: Activities/volunteer coordinator could develop /revise policies for resident choices and educate all facility staff on those policies. The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by:	21620		10/15/20

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21620	Continued From page 23 Based on observation, interview and document review, the facility failed to ensure medication was labeled properly for 1 of 1 resident (R14) reviewed for medications at the bedside. In addition, the facility failed to ensure medications available for use in the South medication cart, was appropriately labeled with an opened date for 1 of 1 residents (R10) reviewed for medication storage. Findings include: R14's quarterly Minimum Data Set (MDS) dated 5/27/20, indicated moderate cognitive impairment and had diagnoses including cancer, atrial fibrilation, heart failure, hypertension, cerebrovascular accident (CVA), and anxiety. R14's physician orders printed on 8/19/20 included triamcinolone acetonide cream 0.5% (used to treat skin inflammation), with directions to apply thin layer to affected areas(s) twice daily as needed. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about the size of a quarter with a whitish scab and a drainage spot on the sock that was about the size of a pinhead. R14 produced a tube of ointment which she stated she routinely applied. The tube lacked a prescription label. During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed R14 had a wound on her left shin and possessed a tube of ointment which lacked an order and appropriate labeling. DON presented the ointment tube to registered nurse (RN)-A, who also denied awareness of the ointment. DON stated R14 lacked an order, appropriate labeling and	21620	Corrected	

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21620	Continued From page 24 assessment for self administration. DON removed the ointment from R14's possession until further evaluation could be completed. Review of the facility's Medication Labeling policy, revised 6/2018, included, "F. Over-the-counter meds brought in by residents may be used if in the original unopened container-labeled as below: -Resident's Name -Date received -Direction for use from the doctor." R10's quarterly MDS dated 5/24/20, R10's diagnosis included diabetes mellitus, disease of the nasal cavity and sinuses, dry eye syndrome. R10's physician orders include Latanoprost ophthalmic (eye) drops, instill one drop into left eye every evening and Fluticasone 50 mcg, instill one spray into each nostril daily. During inspection of the South medication cart on 8/17/20, at 5:30 p.m. with registered nurse (RN) -B, R10's Latanprost ophthalmic (eye) drops were opened, in the cart. There was no opened date on the medication bottle or the prescription bottle the medication was stored in. According to the pharmacy labe on the Latanoprost, this medication was filled by the pharmacy on 7/22/20. R10's Fluticasone, a nasal spray, had an opened date on the medication bottle as well as on the box the medication is stored it. The opened date, handwritten on the medication package and medication bottle, was 4/6. During interview on 8/17/20, at time of medication cart inspection, RN-B stated medications such as ophthalmic drops and nasal sprays were to be labeled with the opened date. RN-B further stated	21620		

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21620	Continued From page 25 Fluticasone should have been discarded six weeks after the medication was opened. RN-B confirmed the ophthalmic drops were opened but not labeled and the Fluticasone was labeled with an opened date, but was past the timeline for safe administration of 6 weeks. During interview on 8/19/20, at 2:13 p.m. director of nursing (DON) stated ophthalmic drops and nasal sprays are expected to be dated with opened date, when the medication is opened. DON further stated, "They should be checking their med carts and expiration dates." Review of the facility policy, Medication Labeling, dated 6/18, did not address the need to date ophthalmic drops or nasal sprays with opened date. Review of the facility policy, Eye Drops, dated 9/18, indicated Latanoprost must be dated upon opening and needed to be discarded six weeks after opening. A request for the facility policy regarding nasal sprays was requested, but was not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		

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21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 1 of 2 residents (R22) upon transfer to the hospital. This had the potential to affect all residents transfers. In addition, the facility failed to notify the Ombudsman for Long Term Care of resident's transfer to the hospital for 1 of 2 residents (R22), reviewed for hospitalization.	21925	Corrected	10/15/20

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21925	Continued From page 27 Findings include: R22's face sheet printed 8/20/20, indicated R22 diagnoses included malignant neoplasm of left main bronchus (lung cancer), Ischemic cardiomyopathy (a condition of weakened heart muscles), atrial fibrillation (irregular heartbeat), pleural effusion (excessive fluid around the lungs) and bronchial obstruction (a blockage in the airway). Progress notes dated 6/27/20, indicated an on call doctor was updated by facility licensed staff when R22 complained of loss of appetite and could not eat his food. Licensed staff assessment include the following findings: temperature 100.7 F, blood pressure 108/64, pulse 106, oxygen saturation 82% (oxygen level in blood), respirations 18, and lung sounds wheezes bilaterally. The progress noted further noted that R22 was sent to the hospital as advised by the on call doctor. Progress note dated 6/28/20 indicated R22 was admitted to the hospital for pneumonia and stable gastrointestinal bleed. R22's medical record lacked evidence of notification of the Ombudsman of R22's transfer to the hospital. During interview on 8/19/20, at 3:15 p.m. licensed social worker (LSW)-A stated a fax was typically sent monthly to the Ombudsman with information of facility initiated resident transfers and discharges. LSW-A further stated the information sent included information of residents sent to and/or admitted to the hospital. The facility's Monthly Notice to MN Office of Ombudsman for	21925		

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21925	Continued From page 28 Long-Term Care of Emergency Acute Care Transfers and Discharges, dated June 2020, was reviewed. R22's name was not noted on this form. LSW-A confirmed these findings, stating, "Obviously it got missed if I didn't write it down." During interview on 8/20/20, at 8:31 a.m. director of nursing (DON) stated she was not sure of the notification of reason for transfer or the notification sent to the Ombudsman and needed to defer those questions to the social worker. During interview on 8/20/20, at 8:42 a.m. registered nurse (RN)-A stated written notification was not usually sent to the resident's representative, but was usually communicated to the representative by phone. RN-A further stated the information provided by phone included the information for the reason the resident was transferred. R22's Progress note dated 6/27/20 lacked further evidence that R22 or R22's representative received a phone call or written notification of the reason for transfer. A facility policy regarding required notification with transfer/discharges was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of	21925		

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21925	Continued From page 29 these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925		