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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HNQY
Facility ID: 00384

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2009**
6. DATE OF SURVEY **06/18/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 07/15/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/12/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245286

July 7, 2015

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

Dear Ms. Rocheleau:

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

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

Effective June 9, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 19, 2015

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

RE: Project Number S5286027

Dear Ms. Rocheleau:

On May 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 30, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 1, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 30, 2015, effective June 9, 2015 and therefore remedies outlined in our letter to you dated May 14, 2015, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245286	A. Building B. Wing	6/18/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	**06/09/2015**	ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	**06/09/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**06/09/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	**06/09/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**06/09/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	**06/09/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	06/19/2015	32603	06/18/2015
CMS RO				

Followup to Survey Completed on: 4/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245286	01 - MAIN BUILDING 01	6/1/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	05/06/2015	ID Prefix Reg. # NFPA 101 LSC K0056	05/07/2015	ID Prefix Reg. # NFPA 101 LSC K0076	05/19/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	06/15/2015	27200	06/01/2015
CMS RO				

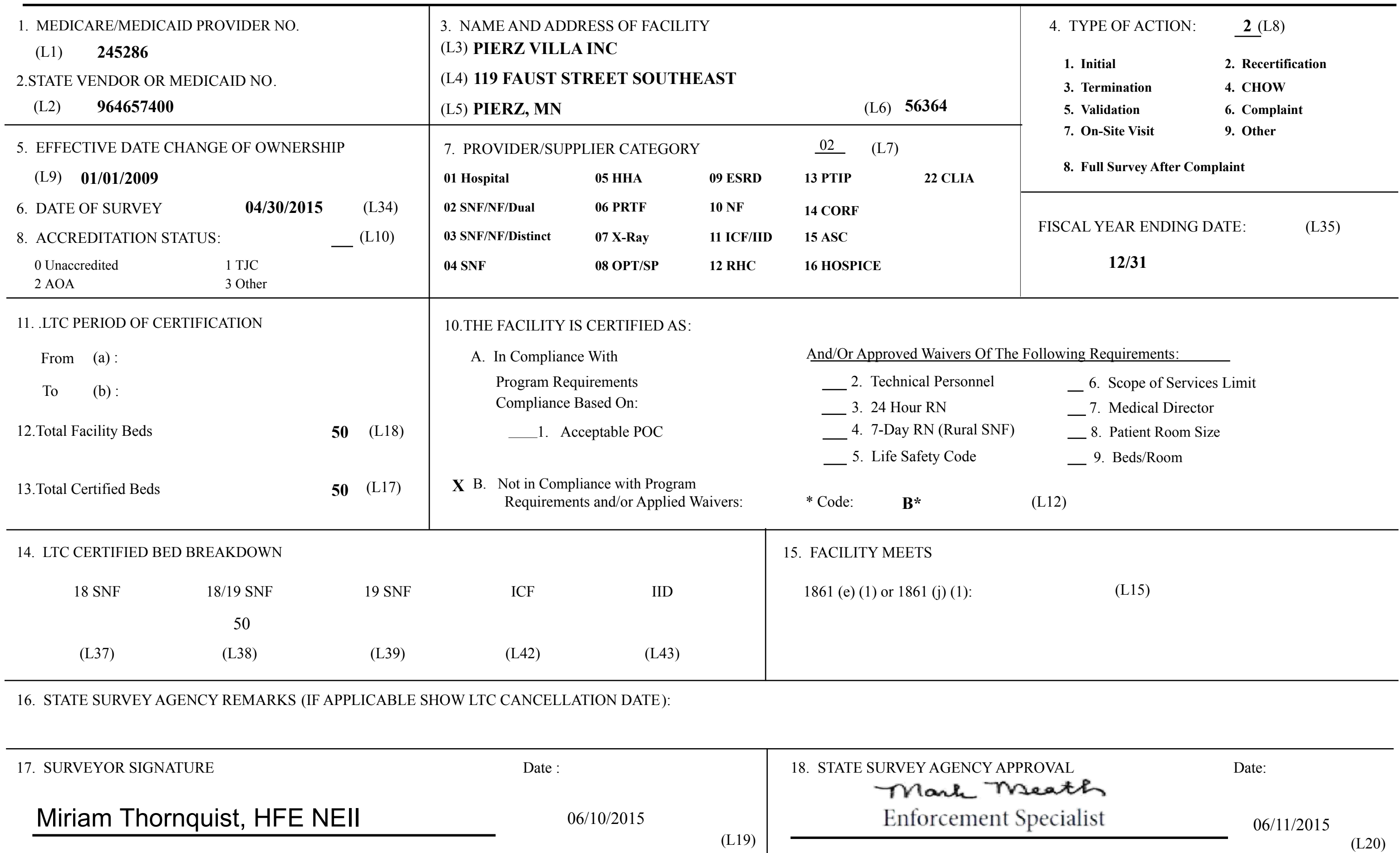
Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/4/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HNQY
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 **04/30/2015** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 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 :
Miriam Thornquist, HFE NEII 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 06/11/2015 (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
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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

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 14, 2015

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

RE: Project Number S5286027

Dear Ms. Rocheleau:

On April 30, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 9, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 9, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 30, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

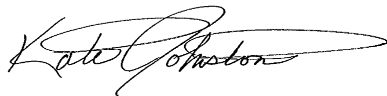
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
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 ______	04/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make prompt efforts to resolve grievances verbalized by 1 of 1 resident (R6) reviewed who had expressed concerns about positioning in the dining room. Findings include: R6's quarterly Minimum Data Set (MDS) dated 4/13/15, indicated R6 was diagnosed with congestive heart failure, had intact cognition and	F 166	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Resident prior to MDH entering our facility was satisfied with her tablemates and had no desire to change seating. However	6/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/21/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245286	A. BUILDING ______ B. WING ______	04/30/2015

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 166	Continued From page 1 was able to perform activities of daily living independently or with staff supervision. R6's care plan dated 1/27/15, identified R6 as cognitively intact and able to make her needs known. On 4/28/15, at 11:00 a.m. R6 stated she was unhappy with her tablemate (R7) in the dining room because she "hits me." She explained the "hits" did not hurt or cause her injury but "she just thinks she is smart." She stated she had discussed the concern with the staff members and they were well aware of the concern but she continued to share a table with R7. She stated she wished R7 did not sit at the same table as she did. The dietary section of the Care Conference note dated 10/28/14, indicated R6 had expressed concerns related to two of her tablemate's arguing during meals and R6 "wouldn't mind moving." The dietary section of the Care conference note dated 1/27/15, read "still waiting for a new table." The dietary section of the Care Conference note dated 4/21/15, did not identify any concerns. On 4/29/15, at 8:40 a.m. registered nurse (RN)-B stated R7 would occasionally tap staff members as they passed her in the hallway but was not	F 166	facility did fail to have this documentation of the conversation. On 4/29/15 LSW again met with R6 in regards to her concerns expressed. R6 told LSW that there is no issue and that she is happy right where she is at and does not want to move. On 5/18/15 LSW once again met with R6 to assure that she continued to be satisfied with her seating arrangement in the dining room and tablemates, she noted that there are no issues and that she liked where she is at. In order to assure that verbal and written concerns of all residents are addressed promptly Pierz Villa will continue to ask each resident if there are any concerns at their quarterly care conference, monthly resident council meetings. Pierz Villa also reviewed current policy and provided all staff education on 5/19 - 5/22/15. As individual concerns are brought to our attention staff may complete a grievance/concern form and route to appropriate department. The concern will be addressed and followed up on with the resident until a resolution is made. Interventions/Resolutions will be documented on the form and/or residents medical record. If concern involves resident safety VA policies are to be followed if appropriate Pierz Villa will review on a weekly basis at the IDT meeting any concerns, voiced or written that the team is aware of and audit them to assure that they have been responded to promptly. These audits will	

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F 166	Continued From page 2 aware of any of the other residents expressing concerns related to R7's behavior. On 4/29/15, at 8:45 a.m. the certified dietary manager (CDM) stated R6 and R7 sat together in the dining room. She stated R6 had expressed concerns related to R7's behaviors in the past. She confirmed R6 had discussed the concerns during care conference. During the October care conference, R6 had requested to change tables, but there were no open tables in the dining room at that time. She stated in January R6 again requested a different table, but there were still no alternative places to sit. She stated she was not aware R7's behaviors during the meals were what was causing R6 to wish to change tables. She stated she had not followed up with the concern as in April 2015, R6 had not continued to express concerns related to dining at the meals. She confirmed R6 and R7 continued to receive their meals at the same dining room table and no further changes had been made. She verified the clinical record lacked documentation related to any type of follow conversations and or interventions to resolve R6's grievance. On 4/29/15, at 9:10 a.m. the licensed social worker stated she had been present at the care conferences and was aware R6 had expressed concerns regarding her tablemate's. She stated R6 had not filled out a grievance form and she stated she would follow up with R6's concern. The undated Filing grievance/complain procedure directed the staff to address all concerns as soon as possible but not exceed 10 working days. The	F 166	be completed for 3 months or until resolved. Pierz Villa will share and discuss the audit results with the Quality Assurance team until the matter is resolved.	

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F 166	Continued From page 3 policy indicated the residents and family members could communicate verbal or written concerns.	F 166		
F 170 SS=F	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to the residents on Saturdays for 1 of 1 (R60) resident reviewed who indicated they did not receive mail on Saturdays. This practice had the potential to affect 48 resident in the facility. Findings include: On 4/29/15, at 2:00 p.m. R60, a representative of the resident council, stated she could not recall if the residents at the facility received main on Saturdays. On 4/29/15, at 2:25 p.m. licensed practical nurse (LPN)-A stated she could not recall if the mail was delivered on Saturdays. On 4/29/15, at 2:30 p.m. activity aide (AA)-A stated the facility had both a rural mail route	F 170	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. On 4/30/15 Pierz Villa contacted the local Postal Office asking if they could deliver our PO Box mail to the physical address on Saturdays. Postal office agreed to deliver PO Box mail to physical address starting 5/2/15. Pierz Villa reviewed the policy on mail delivery and provided education to the activity staff and their duty to deliver the Saturday mail. This will be reviewed with the residents at the next resident council meeting	5/4/15

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F 170	Continued From page 4 address and a post office box. She explained the rural mail was sometimes delivered to the facility early in the morning and other times it was delivered in the afternoon depending on which way the mail carrier delivered the mail. She explained the activity staff were in the facility until noon on Saturdays and they passed the mail only if it came before noon. She stated the post office box mail would was delivered to the residents on Monday. On 4/29/15, at 2:35 p.m. the activity director stated the activity staff delivered the residents mail on Saturdays and stated she had not been made aware the mail may or may not be delivered to the facility before noon on Saturday and if not before noon, the resident would then receive the mail on Monday. She stated the residents were to receive mail Monday- Saturday. On 4/29/15, at 2:40 p.m. the business office manager stated the maintenance director picked the mail up each day at the post office and she would retrieve the mail from the rural mailbox at the front of the facility Monday - Friday. She stated she was not aware how mail was delivered on the weekends. On 4/29/15, at 2:42 p.m. the administrator stated the residents received mail both at the rural route mail box and the post office. She stated the activity staff members picked up the mail delivered to the rural post office box in the front of the building on Saturdays. She stated the maintenance director and herself were the staff members who had keys to post office box and	F 170	scheduled for 5/27/15. Pierz Villa will audit a resident weekly on Monday's for 3 months to verify they received mail on Saturday or until resolved. Pierz Villa will share and discuss the audit findings with the Quality Assurance team until the matter is resolved.	

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F 170	Continued From page 5 she was reluctant to give any staff members the task of retrieving the post office box mail. She stated the local post office lobby was open for only a very limited time on Saturday (less than 2 hours) and she did not have staff who had access to that mailbox working on the weekends, therefore the post office box mail was not picked up. She confirmed any mail delivered to the post office, would not be given to the resident until after it had been picked up on Monday. She was aware residents were to receive mail Monday - Saturday but had not established a system to ensure mail delivery on Saturday. The undated Resident Handbook page four read: "Mail is given to residents Monday-Saturday.	F 170		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		6/9/15

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F 225	Continued From page 6 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the appropriate State agency for 3 of 22 residents (R1, R41, R54) who required reports. Findings include: The Incident Report dated 6/27/14, revealed R1 had been transferred to the local hospital emergency room and was diagnosed with a fractured rib of unknown origin. The facility notified the State agency of the fracture on 6/28/14, (24 hours after the incident.)	F 225	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It shall be made aware that the resident's in F225 and F226 were never suspected of having abuse, neglect or mistreatment done upon them. After reviewing each incident further and comparing to state reporting, it is our interpretation that these 3 incidents may	

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F 225	Continued From page 7	F 225		

The Incident Report dated 1/17/15, indicated R41 was found on the floor in the bathroom with blood coming from her nose. R41 was sent to the hospital and was diagnosed with fractured nose. The State agency was notified of the fracture on 1/19/15, (2 days after the incident.)

The Incident Report dated 2/2/15, indicated R54 had eloped from the facility without supervision and was found on the front sidewalk with a bump on his head. The staff were able to direct R54 back into the facility and notified the on-call physician who directed them to monitor R54. The State agency was notified of the incident on 2/3/15, (24 hours after the incident).

On 4/28/15, at 3:50 p.m. licensed practical nurse (LPN)-B stated she would report any concern of abuse or neglect to the director of nurses (DON). She stated she was not aware how to notify the State agency.

On 4/28/15, at 3:53 p.m. activity aide (AA)-A stated any concerns of abuse would be reported to her supervisor.

On 4/28/15, at 3:55 p.m. the dietary director stated the facility had up to 24 hours to report any concerns of abuse to the State agency.

On 4/28/15, at 4:00 p.m. registered nurse (RN)-A stated the facility could report concerns to the State agency as soon as possible but within 24 hours.

not have needed to be reported.

On 4/29/15 LSW immediately put out a memo to all staff and departments educating them on the policy of VA reporting.

On 5/18/15 all VA policy and procedures were reviewed and updated to reflect immediate reporting without delay and eliminating any language referring to 24 hours. On 5/19/15 -5/22/15 all staff were educated on the updated policy and procedures of VA reporting on the reporting immediately without delay.

All resident incident reports will be reviewed daily to assure that if an incident was reportable that it was completed immediately. Pierz Villa will audit daily for 3 months or until resolved to assure that reporting was immediate, without delay.

Pierz Villa will share and discuss the audit findings with the Quality Assurance team until the matter is resolved.

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F 225	Continued From page 8	F 225		

On 4/28/15, at 4:04 p.m. LPN-C stated the facility had up to 24 hours to notify the State agency.

On 4/28/15, at 4:10 p.m. RN-B stated she had sent potential vulnerable adult concerns of abuse to the State agency. She stated she preferred to send any concerns in right away but the facility had up to 24 hours to complete the reports then submit.

On 4/28/15, at 4:15 p.m. the activity director stated the facility had up to 24 hours to report any concerns to the State agency.

On 4/29/15, at 8:30 a.m. nursing assistant (NA)-D stated any concerns of abuse or neglect were to be report to the State agency within 24 hours.

On 4/29/15, at 8:50 a.m. NA-E stated the facility had up to 24 hours to report concerns to the State agency.

On 4/29/15, at 9:00 a.m. the DON stated all of the staff have been given instructions on how to complete potential vulnerable adult concerns to the State agency. She stated the staff were to report the concerns as soon as possible, but they were not to exceed 24 hours.

On 4/29/15, at 10:00 a.m. licensed social worker (LSW)-A stated the facility had up to 24 hours to

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F 225	Continued From page 9	F 225		

report concerns of abuse or neglect. She reviewed the incident reports involving R41, R1 and R54. She verified with the exception of R41's concern (in which the State agency was notified 2 days later), the other three reports were not completed immediately but were completed within 24 hours.

On 4/29/15, at 10:10 a.m. the administrator stated she expected all staff to report concerns related to potential abuse and/or neglect to the State agency immediately but not to exceed 24 hours.

The Abuse Neglect and Misappropriation of Property- Vulnerable Adult Abuse and Neglect Prevention Plan dated 8/2013, directed the staff to conduct an initial evaluation of the incident to determine if the incident was reportable. If the incident was determined reportable, the Administrator and DON were to be notified immediately. If the administrator determined the State Agency was not be notified, he/she would ensure this was completed. The policy did not direct the staff as to when the report was to be completed.

The Abuse/Neglect and Misappropriation Policy dated 8/2013, also directed the staff to report concerns immediately, as defined "as soon as possible but ought not exceed 24 hours."

The Reporting of Accident and Unusual Incidents dated 8/2013, read: "Any incident/accident resulting in bodily injury of a resident that is

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F 225	Continued From page 10 unexplainable and suspicious of abuse in nature/ requiring medical attention from a physician, a report will be made immediately but out not to exceed 24 hours after the discover of the incident."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop written abuse and neglect polices which would direct the staff to report allegations of potential mistreatment to the appropriate State agency timely. This had the potential to affect for 3 of 22 residents (R1, R41, R54) who required reports. Findings include: The Abuse Neglect and Misappropriation of Property- Vulnerable Adult Abuse and Neglect Prevention Plan dated 8/2013, directed the staff to conduct an initial evaluation of the incident to determine if the incident was reportable. If the incident was determined reportable, the Administrator and DON were to be notified immediately. If the administrator determined the State agency was to be notified, he/she would	F 226	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It shall be made aware that the resident's in F225 and F226 were never suspected of having abuse, neglect or mistreatment done upon them. After reviewing each incident further and comparing to state reporting, it is our interpretation that these 3 incidents may not have needed to be reported. On 4/29/15 LSW immediately put out a	6/9/15

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F 226	Continued From page 11 ensure this was completed. The policy did not direct the staff as to when the report was to be completed. The Abuse/Neglect and Misappropriation Policy dated 8/2013, also directed the staff to report concerns immediately, as defined "as soon as possible but ought not exceed 24 hours." The Reporting of Accident and Unusual Incidents dated 8/2013, read: "Any incident/accident resulting in bodily injury of a resident that is unexplainable and suspicious of abuse in nature/ requiring medical attention from a physician, a report will be made immediately but out not to exceed 24 hours after the discover of the incident." This policy is incorrect as immediately is defined as "without delay" and does not include a 24 hour window. The Incident Report dated 6/27/14, revealed R1 had been transferred to the local hospital emergency room and was diagnosed with a fractured rib of unknown origin. The facility notified the State agency of the fracture on 6/28/14, (24 hours after the incident.) The Incident Report dated 1/17/15, indicated R41 was found on the floor in the bathroom with blood coming from her nose. R41 was sent to the hospital and was diagnosed with fractured nose. The State agency was notified of the fracture on 1/19/15, (2 days after the incident.)	F 226	memo to all staff and departments educating them on the policy of VA reporting. On 5/18/15 all VA policy and procedures were reviewed and updated to reflect immediate reporting without delay and eliminating any language referring to 24 hours. On 5/19/15 -5/22/15 all staff were educated on the updated policy and procedures of VA reporting on the reporting immediately without delay. All resident incident reports will be reviewed daily to assure that if an incident was reportable that it was completed immediately. Pierz Villa will audit daily for 3 months or until resolved to assure that reporting was immediate, without delay. Pierz Villa will share and discuss the audit findings with the Quality Assurance team until the matter is resolved.	

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F 226	Continued From page 12 The Incident Report dated 2/2/15, indicated R54 had eloped from the facility without supervision and was found on the front sidewalk with a bump on his head . The staff were able to direct R54 back into the facility and notified the on-call physician who directed them to monitor R54. The State agency was notified of the incident on 2/3/15, (24 hours after the incident.) On 4/28/15, at 3:50 p.m. licensed practical nurse (LPN)-B stated she would report any concern of abuse or neglect to the director of nurses (DON). She stated she was not aware how to notify the State agency. On 4/28/15, at 3:53 p.m. activity aide (AA)-A stated any concerns of abuse would be reported to her supervisor. On 4/28/15, at 3:55 p.m. the dietary director stated the facility had up to 24 hours to report any concerns of abuse to the State agency. On 4/28/15, at 4:00 p.m. registered nurse (RN)-A stated the facility could report concerns to the State agency as soon as possible but within 24 hours. On 4/28/15, at 4:04 p.m. LPN-C stated the facility had up to 24 hours to notify the State agency. On 4/28/15, at 4:10 p.m. RN-B stated she had sent potential vulnerable adult concerns of abuse	F 226		

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 ______	04/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 13 to the State agency. She stated she preferred to send any concerns in right away but the facility had up to 24 hours to complete and submit the reports. On 4/28/15, at 4:15 p.m. the activity director stated the facility had up to 24 hours to report any concerns to the State agency. On 4/29/15, at 8:30 a.m. nursing assistant (NA)-D stated any concerns of abuse or neglect were to be report to the State agency within 24 hours. On 4/29/15, at 8:50 a.m. NA-E stated the facility had up to 24 hours to report concerns to the State agency. On 4/29/15, at 9:00 a.m. the DON stated all of the staff had been given instructions on how to complete potential vulnerable adult concerns to the State agency. She stated the staff were to report the concerns as soon as possible, but they were not to exceed 24 hours. On 4/29/15, at 10:00 a.m. licensed social worker (LSW)-A stated the facility had up to 24 hours to report concerns of abuse or neglect. She reviewed the incident reports involving R41, R1, R54 and verified with the exception of R41's concern (in which the State agency was notified 2 days later), the other three reports were not completed immediately but were completed within 24 hours.	F 226		

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F 226	Continued From page 14 On 4/29/15, at 10:10 a.m. the administrator stated she expected all staff to report concerns related to potential abuse and/or neglect to the State agency immediately but not to exceed 24 hours.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide upper extremity restorative nursing services as directed by the written care plan for 1 of 3 residents (R72) in the sample who required assistance with restorative nursing. Findings include: R72's care plan dated 1/14/15, directed staff to assist R72 with an exercise program three times a week. The program included elbow flexion bilaterally with a one pound weight including push/pull exercises. The plan also directed staff to complete shoulder exercises with a red Thera-a-Band (elastic exercise band). Review of the Rehab documentation and	F 282	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. R72 has not lost any ROM in her upper extremities and is fairly mobile with facility staff in getting around with a walker and continues to play piano. On 4/29/15 the DON addressed R72's refusals of participating in the restorative program. RN faxed MD on 4/29/15 and received an OT order to eval and treat. OT re-evaled R72's restorative program.	6/9/15

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F 282	Continued From page 15 Treatment Record revealed the following: - January 2015, R72 participated in the therapy program three times and refused the program twice. - February 2015, R72 participated in the program seven times and refused to participate four times. - March 2015, R72 participated in the exercise program one time. - April 2015, R72 had not participated in the exercise program. On 4/29/15, at 8:40 a.m. RNA-B stated R72 had consistently been refusing the restorative program. On 4/29/15, at 11:32 a.m. RNA-A stated she had asked R72 to participate in the restorative program three times but she had consistently refused. On 4/29/15, at 1:20 p.m. RNA-A stated the director of nurses (DON) reviewed the restorative programs and was aware R72 had been refusing to participate. On 4/29/15, at 1:40 p.m. the DON confirmed R72 had not participated in therapy as directed by the care plan. The Care Plans policy dated 2/2012, identified the frequency of which care plans were reviewed, but it did not direct the staff to ensure the care plans were followed as written.	F 282	All resident's that are on a restorative program had their programs reviewed and care plans updated prn by the DON on 5/13 - 5/14/15. The policy and procedure was also reviewed and updated to reflect care plan implementation of the restorative program by the DON. All restorative nursing staff will be educated on the restorative nursing and care plan implementation policies and procedures to assure the care plan is being implemented and followed, along with how to communicate when a resident is consistently refusing their program(s). All resident restorative programs will be reviewed weekly at IDT meeting by RN Case Manager. Case Manager is to assure that all restorative programs are being completed and updates/changes are being care planned and implemented appropriately. RN case manager may receive a rehab concern form in regards to residents changes of condition from the rehab staff and RN will assess the residents program which includes observation. Observational audits will be completed on R72 and 3 other residents weekly for the next 3 months or until resolved to assure that consistent refusals are being communicated to RN timely. Audits for resident restorative refusals will be audited 3x week for 3 months to assure that consistent refusals are being communicated to RN timely.	

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F 282	Continued From page 16	F 282	Pierz Villa will share and discuss the audit finding with the Quality Assurance team until the matter is resolved.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to prevent a decrease in range of motion (ROM) for 1 of 3 residents (R72) in the sample who had a range of motion program. Findings include: R72's significant change Minimum Data Set (MDS) dated 3/25/15, indicated R72 was diagnosed with Alzheimer's dementia, had severe cognitive impairment and required extensive assistance with dressing, grooming and bathing. R72's care plan dated 1/14/15, directed staff to assist R72 with an exercise program three times a week. The program included elbow flexion	F 318	This plan of correction constitutes Pierz Villa's written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. R72 has not lost any ROM in her upper extremities and is fairly mobile with facility staff in getting around with a walker and continues to play piano. On 4/29/15 the DON addressed R72's refusals of participating in the restorative program. RN faxed MD on 4/29/15 and received an OT order to eval and treat. OT re-evaled R72's restorative program.	6/9/15

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F 318

Continued From page 17

bilaterally with a one pound weight including push/pull exercises. The plan also directed the staff to complete shoulder exercises with a red Thera-a-Band (elastic exercise band).

The Occupational Therapy Communication Form dated 1/13/15, indicated R72 had been discharged from occupational therapy and a functional maintenance program was established for R72. The program directed staff to assist R72 with upper body range of motion with a one pound weight which included elbow flexion and shoulder flexion.

Review of the Rehab documentation and Treatment Record revealed the following information:

- January 2015, R72 participated in there therapy program 3 times and refused the program x 2.
- February 2015, R72 participated in the program 7 times and refused to participated x 4.
- March 2015, R72 participated in the exercise program one time.
- April 2015, R72 had not participated in the exercise program.

The Rehab Progress Notes dated 1/14/15, and 2/5/15, revealed the restorative nursing assistants (RNA) had identified R72's restorative programs. However, the RNA documentation did not address if R72 completed the programs and did not mention R72's refusals.

The Progress Notes dated 1/14/15,- 4/30/15,

F 318

All resident's that are on a restorative program had their programs reviewed and care plans updated prn by the DON on 5/13 - 5/14/15. The policy and procedure was also reviewed and updated to reflect care plan implementation of the restorative program by the DON.

All restorative nursing staff will be educated on the restorative nursing and care plan implementation policies and procedures to assure the care plan is being implemented and followed, along with how to communicate when a resident is consistently refusing their program(s).

All resident restorative programs will be reviewed weekly at IDT meeting by RN Case Manager. Case Manager is to assure that all restorative programs are being completed and updates/changes are being care planned and implemented appropriately. RN case manager may receive a rehab concern form in regards to residents changes of condition from the rehab staff and RN will assess the residents program which includes observation.

Observational audits will be completed on R72 and 3 other residents weekly for the next 3 months or until resolved to assure that consistent refusals are being communicated to RN timely. Audits for resident restorative refusals will be audited 3x week for 3 months to assure that consistent refusals are being communicated to RN timely.

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F 318	Continued From page 18 lacked documentation related to the restorative program. On 4/29/15, at 8:40 a.m. RNA-B stated R72 had consistently been refusing the restorative program. On 4/29/15, at 11:32 a.m. RNA-A stated she had asked R72 to participate in the restorative program three times but she had consistently refused. On 4/29/15, at 11:35 a.m. RNA-A was observed to assist R72 to ambulate 80 feet with a front wheeled rolling walker. R72 was observed hunched over as she walked but was able to complete the ambulation task. On 4/29/15, at 1:20 p.m. RNA-A stated the director of nurses (DON) reviewed the restorative programs and was made aware R72 had been refusing to participate. On 4/29/15, at 1:30 p.m. the DON stated registered nurse (RN)-B overseen the restorative programs and all restorative programs were reviewed at the interdisciplinary meets (IDT) meetings each week. She stated if the IDT determined that a resident was not participating in the program as directed, they would contact the therapy department. She confirmed none of the staff members from the IDT documented any of the concerns identified at the IDT meetings in the individual resident clinical records.	F 318	Pierz Villa will share and discuss the audit finding with the Quality Assurance team until the matter is resolved.	

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F 318	Continued From page 19	F 318		

On 4/29/15, at 1:35 p.m. RN-B stated she communicated any nursing changes to the rest of the nursing team. She stated R72 did not routinely like to participate in the restorative program but would complete the exercises when she wished. She confirmed she was aware R72 was not completing the program and the clinical record lacked documentation related to the refusals and interventions attempted to encourage R72 to complete the program.

On 4/29/15, at 1:40 p.m. the DON confirmed R72 had not participated in therapy as directed by the care plan.

On 4/29/15, at 1:45 p.m. the DON directed R72 to move her arms and shoulders. R72 was observed to have full range of motion bilaterally with mild stiffness in the left shoulder. The DON confirmed R72 had not participated in the program as directed and had not developed a decline in range of motion.

On 4/30/15, at 12:00 p.m. the occupational therapist (OT)-A stated the facility had informed her a couple a weeks ago that R72 was not participating in the restorative program. She directed the staff to approach R72 differently and to report back to her if R72 continued to refuse. She stated she was not aware R72 had consistently refused the program since the end of February. She stated R72 should have been referred back to therapy for further evaluation.

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F 318	Continued From page 20 The Rehabilitation Nursing Care policy dated 5/2012, directed the staff to ensure the nursing staff follow the directions for restorative care as directed by the therapist.	F 318		

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

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FORM APPROVED
OMB NO. 0938-0391

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/04/2015**

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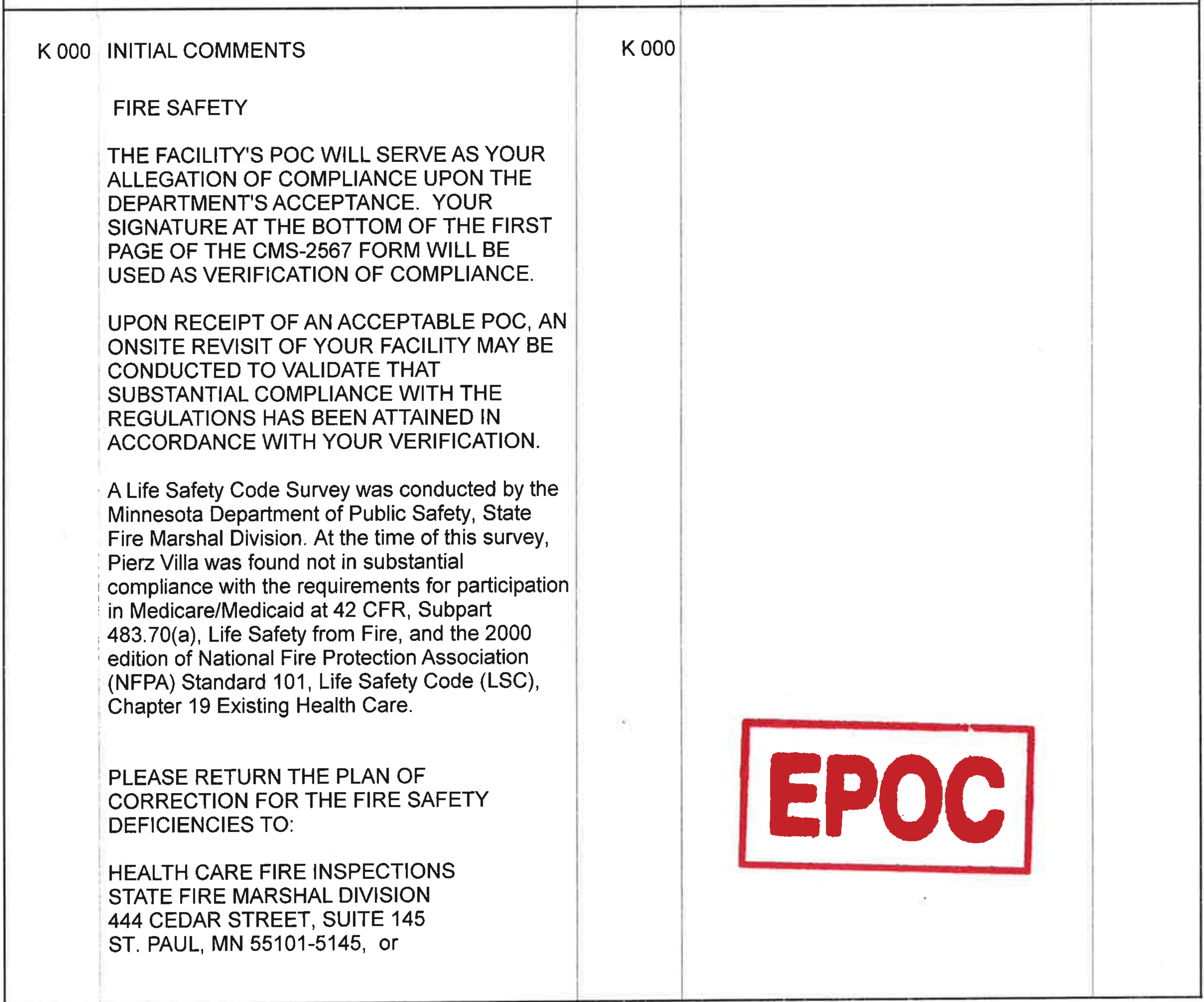

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pierz Villa was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/21/2015

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	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Barbara.lundberg@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Pierz Villa is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and is now Type V(111) construction because of a new roof system that includes wood sheathing over the existing roof system. In 1983, an addition was added to the south that was determined to be of Type V(111) construction. In 1994, another addition was added to the southeast of the that was determined to be of Type V(111) construction. Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors.	K 029	On May 6, 2015 the maintenance supervisor repaired and sealed up the penetrations observed in the ceiling of the S-10 storage area. On May 6, 2015 the maintenance supervisor repaired and sealed up the penetration found around the sprinkler head located in the S-9 storage room. On May 6, 2015 the door to the S-10 storage room was equipped with a self closing hinge place on the door.	5/6/15

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K 029	Continued From page 3 Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/04/2015, observation revealed the following deficient conditions affecting 2 of several hazardous areas located throughout the facility: 1. there was a penetration found in the ceiling around the sprinkler head located in the S-9 Storage room 2. there were multiple penetrations found in the ceiling of the S-10 Storage 3. the door to the S-10 storage room was not equipped with a self closing device This deficient condition was verified by the Maintenance Supervisor (CO).	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by:	K 056		5/7/15

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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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 4 Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/04/2015, observations revealed that there are two different type of sprinkler heads located in the chapel consisting of both standard response and quick response which are combined in one compartment. This deficient condition was verified by the Maintenance Supervisor (CO).	K 056	On May 7, 2015 the sprinkler head coated in the chapel were changed out to all be a quick response head by the Fire protection company.	
K 076 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		5/19/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245286	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	(X3) DATE SURVEY COMPLETED 05/04/2015

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K 076	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations it was revealed that the oxygen storage rooms was not in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could residents and staff, and visitors in the event of an emergency. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/04/2015, observations reveled that there were 10 E-size oxygen cylinders that were not properly secure in a rack located in the facility's oxygen storage room. This deficient condition was verified by the Maintenance Supervisor (CO).	K 076	On 5/4/15 the immediate problem was corrected. On 5/8/15 maintenance supervisor ordered more oxygen tank holders from the oxygen supply company. The racks were delivered on May 11, 2015 and are currently being used. Nursing staff had education on 5/19/15 to educate them on the importance of oxygen storage in the racks. Audits of this room will be completed by the maintenance supervisor 2x week for one month and then 1x week for two months. The audits will be shared with our QA team until the matter is resolved.	