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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MYWK

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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

6. DATE OF SURVEY **09/15/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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: **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 :
Michelle Thompson, HFE NE II 09/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 10/26/2016 (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) **00**

VOLUNTARY
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 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/30/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245286
October 26, 2016

Ms. Kim Rocheleau, Administrator
Pierz Villa, Inc.
119 Faust Street Southeast
Pierz, MN 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 September 9, 2016 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 26, 2016

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

RE: Project Number S5286028

Dear Ms. Rocheleau:

On August 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 12, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2016, effective September 9, 2016 and therefore remedies outlined in our letter to you dated August 9, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245286	A. Building B. Wing	9/15/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 09/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 10/26/2016	SIGNATURE OF SURVEYOR 28598	DATE 09/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245286 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/12/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	08/16/2016	LSC K0015	08/10/2016	LSC K0017	08/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	07/27/2016	LSC K0025	08/01/2016	LSC K0029	08/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	08/09/2016	LSC K0051	08/01/2016	LSC K0056	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	09/09/2016	LSC K0064	07/27/2016	LSC K0070	08/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0074	07/27/2016	LSC K0147	08/09/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	10/26/2016	27200	09/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/26/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00384 Y1	A. Building B. Wing Y2	9/15/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 09/04/2016	ID Prefix 21565 Reg. # MN Rule 4658.1325 Subp. 4 LSC	Correction Completed 09/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 10/26/2016	SIGNATURE OF SURVEYOR 28598	DATE 09/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MYWK

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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

6. DATE OF SURVEY **08/18/2016** (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 :
Jennifer Bahr, HFE NE II — 08/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/25/2016 (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: **00** (L30)

VOLUNTARY
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 08/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 9, 2016

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

RE: Project Number S5286028 & H5286021

Dear Ms. Rocheleau:

On July 26, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5286021 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
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 September 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2017 (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 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. 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	07/20/2016

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. A complaint investigation was also completed at the time of the standard survey, complaint H286021, and was unsubstantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for safe self administration of medication via a nebulizer for 2 of 6 residents (R5, R8) observed during medication administration. Findings include: R5 was observed on 7/19/16, at 3:14 p.m. sitting	F 176	On 7/20/2016 RN Case Manager completed self-administration assessments on R5 & R8. R5□s MD was faxed for order for self-adminstration of nebulizers after set-up.; Order was received; EMAR updated and care plan updated. R8 was deemed not able to self	9/4/16

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

Electronically Signed | 08/17/2016

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F 176	Continued From page 1 in his recliner with his eyes closed. R5's nebulizer machine was running and he was inhaling the medication from the mask of the nebulizer (where medication is aerosolized and inhaled by the resident). A nurse was not present in R5's room monitoring R5's nebulizer treatment during the administration of the medication. On 7/19/16, at 3:14 p.m. licensed practical nurse (LPN)-A stated R5 did not have an order for self administration of medication for a nebulizer treatment in his medical record. LPN-A further stated she was not in R5's room during the nebulizer treatment and would periodically check on him throughout the treatment. R5's medical recorded lacked a nursing assessment for self administration of medications. R5's signed physician order sheet dated 7/8/16, identified an order for albuterol sulfate (an inhaled medication used for shortness of breath)...NEBULIZATION solution... Inhale 3 ml (milliliters) via a nebulizer as needed four times a day. R5's physician orders did not identify if he could self administer the medication. R8 was observed on 7/19/16, at 2:47 p.m. sitting in her wheelchair in her room putting together a puzzle. LPN-B started R8's nebulizer and left the room, leaving R8 unattended with her nebulizer treatment. R8 was observed taking the nebulizer mask away from her face several times as she continued to work on her puzzle. During interview on 7/19/16, at 2:47 p.m. LPN-B stated R8 did not have an order for self administration of medications for her nebulizer	F 176	administer after nebulizer set-up. EMAR and care plan updated with assessment information per facility protocol. All other resident self-administration assessments were completed along with reviewal of EMAR and care plan on 7/20/2016. On 7/21/2016 the Self-Administration of Medication policy and procedure was reviewed and revised. Education on policy and procedure was given to staff during meeting on 7/26/2016 and also a through email on 8/9/2016. Audits will be completed on R5 & R8 and all other residents quarterly, all new admissions who have nebulizer orders and on residents who receive orders for nebulizers that will need self-administration assessment completed for the next 3 months or until resolved to assure we are in compliance. Pierz Villa will share and discuss the audit findings with the Quality Assurance team until matter is resolved.	

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F 176	Continued From page 2	F 176		

treatments. LPN-B further stated R8 did not like be watched, but staff needed to "keep a close eye on her" because R8 would often set the nebulizer mask on the table during her treatments.

R8's medical recorded lacked a nursing assessment for self administration of medications.

R8's signed physician order sheet dated 5/29/16, identified R8 had dementia with severe cognitive impairment. R8's physician order sheet identified an order for ipratropium-albuterol (an inhaled medication used for shortness of breath)...NEBULIZATION solution... Inhale 3 ml via a nebulizer four times a day. R8's physician orders did not identify if she could self administer the medication.

During interview on 7/19/16, at 3:45 p.m. registered nurse (RN)-A stated residents did not need a self administration of medication assessment for nebulizer treatments. RN-A further stated if there was an issue with the nebulizer treatment, facility staff would make a notation in the resident's chart in the medical administration record section.

During interview on 7/20/16, at 7:15 a.m. director of nursing (DON) stated the facility process for self administration of medication included an assessment for safety, obtaining a physicians order allowing them to self administer medications and placing a notation in the resident's care plan. The DON further stated R5 and R8 should not have been left alone with the nebulizer without being assessed and having a physician order obtained.

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F 176	Continued From page 3 A facility policy titled Self administration of Medications by Residents dated 12/05, identified the facility should obtain a written order from the attending physician for specific medication (s) which can be self administered by the resident. Further, an approval from the interdisciplinary team or RN case manager for the resident to self administer nebulizer treatments after set up should be based on the residents ability of holding the nebulizer apparatus and quarterly review by the IDT team. The policy did not address a nursing assessment for safety prior to the self administration of medications.	F 176		

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2016**

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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 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 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/17/2016

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 Marian.Whitney@state.mn.us and Angela.Kappenman@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 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 partially fire sprinkler protect due to K56 deficiencies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 50 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations and staff interviews revealed the following deficient conditions: 1. The double doors in the 2 hour fire barrier separating the Rose Manner Senior Living facility	K 011	On August 16, 2016 a field inspection was completed by a professional company to rate the doors. The doors are rated at a 90 minute fire door and labels were applied. On August 8, 2016 the maintenance supervisor applied a gravity coordinator so that the doors will close in sequence.	8/16/16

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K 011	Continued From page 3 from the Pierz Villa Care Center did not have fire rating labels that specifically specified the fire rating of the doors. 2. The doors in the 2 hour fire barrier separating the Rose Manner Senior Living facility from the Pierz Villa Care Center were same side swinging doors with an astragal and were not equipped with a sequencing device that would ensure the doors would close and latch into the frame and not be obstructed by the astragal. This deficient condition was verified by a Maintenance Supervisor (CO).	K 011		
K 015 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to provide interior finish materials that meet the fame spread requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 10.2.3, 19.3.3.1 and 19.3.3.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 015	Documentation was obtained from the manufacturer of the wood paneling. In order to comply with NFPA 101 to meet the flame spread requirement the maintenance supervisor applied a flame retardant spray to the wood paneling on 8/10/16.	8/10/16

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K 015	Continued From page 4 On facility tour between 10:00 AM to 5:30 PM on 07/26/2016 observations and staff interviews revealed that there was wood panel wainscoting located in the resident lounge across from the laundry department that did not have any visible labels verifying the fire rating on the wood paneling. After a interview with the Maintenance Supervisor (CO), it was determined that the facility did not have any documentation annotating or verifying the flame spread rating on the wainscot paneling at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor (CO).	K 015		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had an opening in the corridor wall located in the facility that is not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.5.2 and 19.3.6.1 in resisting the passage of smoke. This	K 017	On August 1, 2106 the facilities fire alarm company was on site to add a smoke detector to the office. This alarm is a part of the supervised fire alarm system.	8/1/16

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K 017	Continued From page 5 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 42 of 42 residents, as well as an undetermined number of staff, and visitors of the facility. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations and staff interviews revealed, that the receptionist office has a sliding window that is open to the corridor and does not resist the passage of smoke. The receptionist office is protected by standard response sprinkler heads on the facility's fire sprinkler system, but is not equipped with a smoke detector that is part of the supervised fire alarm system. This combination found in the receptionist 's office does not meet 19.3.6.1 exception 1 sections "b" and "c". This deficient condition was verified by a Maintenance Supervisor (CO).	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018		7/27/16

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K 018	Continued From page 6 door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 12 of 42 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations and staff interviews revealed that the corridor door to resident room 102 in the northwest wing did not positively latch into the frame when tested during the facility tour. This deficient condition was verified by a Maintenance Supervisor (CO).	K 018	On July 27, 2016 the maintenance supervisor fixed resident room door 102 so that it will positively latch into the door frame. All other doors in the building were checked by maintenance supervisor.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of 5 several smoke	K 025	On August 1, 2016 the maintenance supervisor filled in the opening above both	8/1/16

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K 025	Continued From page 7 barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 15 of 42 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations and staff interviews revealed the following deficient conditions: 1. The smoke barrier wall located by the activity room had penetrations found around a pipe and section of conduit that was passing through the smoke barrier above the ceiling tile over the double doors. 2. The smoke barrier wall located by the laundry department had a 3 inch diameter hole found above the ceiling tiles over the double doors. This deficient condition was verified by a Maintenance Supervisor (CO).	K 025	areas noted with fire retardant silicone.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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	K 029		8/12/16

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	245286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2016**

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

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K 029	Continued From page 8 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 for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) 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 13 of 42 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations and staff interviews revealed that the door to the air handling mechanical room did not fully close and positively latch into the frame when tested during the facility tour. This deficient condition was verified by a Maintenance Supervisor (CO).	K 029	On August 12, 2016 the maintenance supervisor attached a self-closing device on the door to the air handling mechanical room.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.1.6.2, 7.2.1.5.1, 7.2.1.5.4, 19.2.1, and 19.2.2.2.4. This deficient practice could affect 42 of 42 residents, as well as an	K 038	On July 29, 2016 the maintenance supervisor removed the padlocks on the gates in the courtyard and applied a device that does not require a key or a tool to exit the gate in case of emergency. On July 29, 2016 the maintenance	8/9/16

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K 038	Continued From page 9 undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews revealed the following deficient conditions: 1. It was observed that the two exit gates in the fenced in courtyard area that is being used as an egress discharge were locked with padlocks at the time of the facility tour. 2. It was observed that the employee entry/exit door was equipped with a thumb-turn deadbolt style of lock being use to latch the exit door into the frame. the Deadbolt lock of this style was not readily recognizable as being locked or unlocked. 3. The exit discharges located at the southwest exit, dining room exit, and the chaple exit had an elevation change at the exit door threshold greater than 1 inch as measured at the time of the facility tour. This deficient condition was verified by a Maintenance Supervisor (CO).	K 038	supervisor changed out the door knob at the employee entrance/exit so that it can be readily opened from the egress side. On August 9, 2016 a concrete company was her to fix the elevation level at the exits. All other exits were checked and corrected as needed.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system.	K 051		8/1/16

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K 051	Continued From page 10 Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.1 and 9.6, as well as the NFPA 72 "National Fire Alarm Code" 1999 edition section 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 9 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observations revealed the smoke detectors located at the end of the southwest corridor near the exit there was installed within 36 inches of HVAC diffusers which is within the air flow of the heating, ventilation and air conditioning diffuser.	K 051	On August 1, 2016 the facilities fire company was here and relocated the smoke detector so that it was not within 36 inches of the HVAC diffuser. All other smoke detectors were checked by the maintenance supervisor.	

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K 051	Continued From page 11 This deficient condition was verified by a Maintenance Supervisor (CO).	K 051		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility faille to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. This deficient condition id causing a decrease in the fire protection system capability in the event of an emergency that could affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews revealed the following deficient conditions: 1. There are standard and quick response fire sprinkler heads mixed in the same compartment that are located in the Training/Conference	K 056	On August 16, 2016 the fire/sprinkler company was here to begin the work on #1 and #2. #1-The dryheads were measured and ordered for the meeting room. These may take up to two weeks before they arrive. As soon as the heads arrive they will be installed by the company. #2-The fire/sprinkler company also installed sprinkler protection on 8/16/16 in the kitchen area.	9/9/16

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K 056	Continued From page 12 rooms. 2. The area located behind the kitchen's cooking hood is not provided with fire sprinkler protections. The current configuration and coverage of the sprinkler heads located in the kitchen are blocked by the cooking hood and are not providing coverage to the area behind the hood system. This deficient condition was verified by a Maintenance Supervisor (CO).	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly maintain the automatic sprinkler system in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1, and "The Standard for the Installation of Sprinkler Systems" 1999 edition section 3-2.7.2, 3-2.6.3, 5-5.6, and 6-1.1.5. This deficient practice does not ensure that the fire sprinkler system will function properly and is fully operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews	K 062	On July 27, 2016 the maintenance supervisor put on missing escutcheon rings in the 3 rooms they were found missing. All other sprinkler heads were checked for missing rings. On August 16, 2016 the fire/sprinkler company was here to measure and ordered the dryhead to replace the current painted sprinkler head in room 212. The dryhead will take approximately 2 weeks to arrive. Once the head arrives the company will replace the sprinkler head. On July 28, 2016 the maintenance supervisor removed shelving from linen closets and also applied visible tape for staff to see that nothing should be place/stacked above that line. Education	9/9/16

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K 062	Continued From page 13 revealed the following deficient conditions: 1. There are escutcheon rings missing in resident rooms 202, 211, and 216. 2. there is a painted fire sprinkler head located in resident room 212. 3. There was storage found to be within 18 inches of the fire sprinkler deflector in the clean linen room across from resident room 110. 4. There was a paper bag filled with crumpled scraps of of paper attached to the sprinkler piping that is located outside by the kitchen loading doors. 5. There was a 1/2 inch crescent shaped opening around a sprinkler head located in the corridor outside of the laundry department. This deficient condition was verified by a Maintenance Supervisor (CO).	K 062	was provided to staff via email and notes to all staff in the building. Audits are being done weekly for 8 weeks to assure that nothing is near the sprinkler head On July 26, 2016 the maintenance supervisor removed the paper bag that was attached to the sprinkler piping. The maintenance supervisor inspected all other sprinkler piping for any items affixed to it. Audits will be completed for 8 weeks on the piping to assure no staff member hangs any items off of it. Verbal education was given to the staff member that applied the paper bag On July 27, 2016 the maintenance supervisor filled the opening around the sprinkler head near laundry with fire retardant silicone. All other sprinkler heads were checked for openings.	
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 9.7.3.2, 19.3.5.6 and the NFPA 10 "Standard for Portable Fire Extinguishers" 1998 edition, section 1-6.6. This deficient practice could affect 10 of 42	K 064	On July 26, 2016 the night stand was removed immediately by staff. Education was provided to staff via email and note. Audits will be completed weekly for 8 weeks to assure that fire extinguishers are not blocked.	7/27/16

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K 064	Continued From page 14 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews revealed that the fire extinguisher locating in the training/conference room was found to be blocked by a night stand. The night stand was moved by staff at the time that it was identified during the inspection. This deficient condition was verified by a Maintenance Supervisor (CO).	K 064		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.8. This deficient practice could affect 10 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 070	On July 29, 2016 the space heater in the administrators office was removed and policy was reviewed and updated to reflect that the facility prohibits the use of space heaters. Education was provided to staff.	8/29/16

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K 070	Continued From page 15 On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews it was revealed that the facility had a space heater that was used in the Administrators office and that the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by a Maintenance Supervisor (CO).	K 070		
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Based on observations there are privacy curtains in the facility that do not meet the requirements for Furnishing, Bedding, and Decorations for use	K 074	On July 27, 2016 all privacy divider curtains were removed in these identified rooms. All other hanging privacy curtains	7/27/16

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K 074	Continued From page 16 in health care occupancies in accordance with provisions of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition section 5-6.5.2.3. This deficient condition is causing a decrease in the fire protection system capability in the event of an emergency that could affect 20 of 42 residents, as well as an undetermined number of staff, and visitors. Findings Include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews revealed the following deficient conditions: 1. The privacy divider curtain located in resident room 205 did not have any labeling attached to it stating that it is "inherently fire retardant". 2. The privacy divider curtain located in resident rooms 203 and 215 has a mesh that had openings that were 1/4 inch as measure and not the required 1/2 inch. This deficient condition was verified by a Maintenance Supervisor (CO).	K 074	in the building were verified to be in compliance upon inspection from the maintenance supervisor.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life	K 147	On August 1, 2016 the maintenance supervisor removed the plug adapters found in both rooms and replaced them with an approved UL 1363RPT. The	8/9/16

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K 147	Continued From page 17 Safety Code" 2000 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 1999 edition, section 9.1.2. This deficient practice could affect 12 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 AM to 5:30 PM on 07/26/2016, observation and staff interviews revealed the following deficient conditions: 1. There are an unapproved multiple plug adaptors found in all of the resident rooms 218 and 219 that do not have a reset breaker on them, 2. There was storage on and against the electrical panels located in the electrical/mechanical room located in the basement of the facility. This deficient practice was confirmed by the Maintenance Supervisor.	K 147	maintenance supervisor checked all other rooms for any additional adapters. The facility created policy that reflects approved powerstrips and no use of adapters or extension cords. Staff were also educated. Safety committee checklists were updated as well to check for these items when doing quarterly room checks. On July 27, 2016 the maintenance supervisor cleared the storage that was blocking the electrical panel in the basement. Audits will be completed 1x week for 8 weeks to assure it is free from blockage.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 9, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number

Dear Ms. Rocheleau:

The above facility was surveyed on July 26, 2016 through July 26, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Terri Ament at 218-302-6151.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
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Enclosure(s)
cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

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 _____	07/20/2016

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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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: 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	2 000		

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2 000	Continued From page 1 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. On 7/18/16-7/20/16, surveyors of this Department's staff, visited the above provider and 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		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to administer the tuberculin skin test (TST) within 72 hours for 1 of 5 residents (R15) who were reviewed for tuberculosis (TB) testing. Findings include: R15 had been admitted to the facility on 6/6/16. A TB symptom screen had been completed upon admission, however, over a month later, a TST had never been administered. R15's Medication Administration Record (MAR) was reviewed since her admission. The MAR noted the following: - On 6/6/16, a TST was not administered with the comment "Drug/Item unavailable." - On 6/20/16, a TST was not administered with the comment "resident asleep." There was no indication a TST had been attempted later. - On 7/5/16, a TST was not administered with the comment "will get done tomorrow." There was no indication a TST was ever attempted. During an interview on 7/20/16, at 1:04 p.m. registered nurse (RN)-A stated the TST should have been administered, but it was deferred due to a facility shortage in the tuberculin solution in the last month. She further stated the TST was due to be administered the next day, 7/21/16, but the facility had just received a stock of solution and it could be administered sooner. Later the same day, at 1:09 p.m. the director of nursing (DON) stated the facility policy was to	21426		

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21426	Continued From page 3 administer the first TST upon admission with a second TST administered two weeks after admission. The DON stated she was in charge of ordering tuberculin solution when the nursing staff notified her it was running low. She was not aware of a shortage of solution in June, however, further stated it had been difficult during the last year to acquire solution from the pharmacy, with shipments typically taking one to two weeks. She reported the facility policy would be to defer TST administration until the solution was available. Facility policy entitled: Tuberculin Shortage Policy (Temporary)- New Employees and Admissions, dated 5/13, directed to defer TST testing "...until shortage resolves," but it did not address any plans to obtain the solution during a shortage. Facility policy entitled: TB Screening for Residents of Nontraditional Facility-Based Settings, revised 3/10, directed that residents of the facility were to be screened and tested for TB, with the tuberculin skin test (TST) being "...administered within 72 hours of admission." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the facility's process/policies to ensure TB solution is ordered in a timely manner and addresses a plan for administration during a shortage. They could also audit to ensure newly admitted residents are administered TB testing as required by state rule. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		

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21565	Continued From page 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: F176 Based on observation, interview and document review, the facility failed to comprehensively assess for safe self administration of medication of nebulizer's for 2 of 2 residents reviewed (R5, R8) with the potential to affect all 6 residents who received inhaled medications. Findings include: During observation on 7/19/16, at 3:14 p.m. R5 was sitting in his recliner with his eyes closed. R5's nebulizer machine was running and he was inhaling the medication from the mask of the nebulizer (where medication is aerosolized and inhaled by the resident). No nurse was present in R5's room monitoring R5's nebulizer treatment during the administration of the medication. When interviewed on 7/19/16, at 3:14 p.m. licensed practical nurse (LPN)-A stated R5 did not have an order for self administration of medication for a nebulizer treatment in his medical record. LPN-A further stated she was not in R5's room during the nebulizer treatment and would periodically check on him throughout the treatment. R5's signed physician order sheet dated 7/8/16,	21565		

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21565	Continued From page 5	21565		

identified an order for abuterol sulfate [an inhaled medication used for shortness of breath from chronic pulmonary disease]...NEBULIZATION solution... Inhale 3 ml (milliliters) via a nebulizer as needed four times a day. R5's physician orders did not identify if he could self administer any medications.

During observation on 7/19/16, at 2:47p.m. R8 was sitting in her wheelchair in her room putting together a puzzle. LPN-B started R8's nebulizer and left the room, leaving R8 unattended with her nebulizer treatment. R8 was observed taking the nebulizer mask away from her face several times as she continued to work on her puzzle.

During interview on 7/19/16 at 2:47 p.m. LPN-B stated R8 did not have an order for self administration of medications for her nebulizer treatments. LPN-
B further stated R8 did not like be watched, but staff needed to "keep a close eye on her" because R8 would often set the nebulizer mask on the table during her treatments.

R8's signed physician order sheet dated 5/29/16, identified R8 had dementia with severe cognitive impairment. R8's physician order sheet identified an order for ipratropium-albuterol [an inhaled medication used for shortness of breath from chronic pulmonary disease]...NEBULIZATION solution... Inhale 3 ml via a nebulizer four times a day. R8's physician orders did not identify if she could self administer any medications.

When interviewed on 7/19/16 at 3:45 p.m. registered nurse (RN)-A stated residents did not need a self administration of medication assessment for nebulizer treatments. RN-A further stated if there was an issue with the

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21565	Continued From page 6 nebulizer treatment, facility staff would make a notation in the residents chart in the medical administration record section. During interview on 7/20/16, at 7:15 a.m. director of nursing (DON) stated the facility process for self administration of medication included an assessment for safety, obtaining a physicians order allowing them to self administer medications and placing a notation in the residents care plan. DON further stated R5 and R8 should not have been left alone with the nebulizer without being assessed and having a physician order obtained. A facility policy titled Self administration of Medications by Residents dated 12/05, identified the facility should obtain a written order from the attending physician for specific medication (s) which can be self administered by the resident. Further, an approval from the interdisciplinary team or RN case manager for the resident to self administer nebulizer treatments after set up should be based on the residents ability of holding the nebulizer apparatus and quarterly review by the IDT team. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physicians order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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