



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered  
September 28, 2026

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

RE: CCN: 245286  
Cycle Start Date: July 23, 2026

Dear Administrator:

On September 22, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2026

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

Re: Reinspection Results  
Event ID: 2AA9FA-H2

Dear Administrator:

On September 22, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 23, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)

*An equal opportunity employer.*



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

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

RE: CCN: 245286

Cycle Start Date: July 23, 2026

Dear Administrator:

On July 23, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor

St. Cloud A District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: [nikki.harvey@state.mn.us](mailto:nikki.harvey@state.mn.us)

Office: (320) 223-7318 Mobile: (320) 216-5631

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

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

If substantial compliance with the regulations is not verified by **October 23, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 23, 2027** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the last name being a large, stylized 'Z'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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Electronically delivered

August 13, 2026

Administrator

PIERZ VILLA INC

119 FAUST STREET SOUTHEAST

PIERZ, MN 56364

Re: State Nursing Home Licensing Orders

Event ID: 2AA9FA-H1

Dear Administrator:

The above facility survey was completed on July 23, 2026, 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Nikki Harvey, Regional Operations Supervisor  
St. Cloud A District Office  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: [nikki.harvey@state.mn.us](mailto:nikki.harvey@state.mn.us)  
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245286 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X3) DATE SURVEY COMPLETED<br><br>07/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PIERZ VILLA INC  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>119 FAUST STREET SOUTHEAST , PIERZ, Minnesota, 56364 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                              | (X5)<br>COMPLETION<br>DATE |
| F0000                                                | INITIAL COMMENTS<br><br>On 7/22/26 through 7/23/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed. H52863446C (3105982). An incidental finding was discovered and cited at F641.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. |                                                                     |  | F0000                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              | 08/21/2026                 |
| F0641<br>SS = D                                      | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     |  | F0641                                                                                             | Pierz Villa strives to ensure that resident assessments accurately reflect each resident's clinical condition and are supported by information contained in the resident's medical record.<br><br>R3's MDS assessment and pressure-ulcer coding to be reviewed and corrected as applicable based on reconciliation of clinical documentation, and in accordance with the CMS requirements and facility policy to ensure accuracy. R3's care plan, treatment orders, and nursing interventions for review and revision as needed to reflect the current clinical condition.<br><br>DON and MDS Coordinator to conduct a review of all residents with a current or recent pressure injury/ulcer, including those identified on admission, during a significant change in condition, or within the active MDS assessment period. Any discrepancies identified will be reviewed and |                                              | 09/10/2026                 |

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 reverse for further 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.

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245286 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY COMPLETED<br><br>07/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PIERZ VILLA INC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>119 FAUST STREET SOUTHEAST , PIERZ, Minnesota, 56364 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              | (X5)<br>COMPLETION<br>DATE |
| F0641<br>SS = D                                     | <p>Continued from page 1</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect facility acquired pressure ulcers for 1 of 1 resident (R3) reviewed with a pressure ulcer.</p> <p>Findings include:</p> <p>R3’s Face Sheet indicated she admitted to the facility 6/11/26. R3’s diagnoses included contact dermatitis, pressure ulcers of buttocks right and left, and pressure ulcer of sacral region.</p> <p>R3’s hospital Progress Notes dated 6/5/26, identified pressure injuries to right and left heels.</p> <p>R3’s Head to Toe Skin Assessment dated 6/11/26, identified blanchable redness to R3’s buttocks. The assessment indicated R3 did not have a pressure ulcer.</p> <p>R3’s care plan dated 6/11/26, identified a risk for pressure ulcers. The care plan was updated 6/15/26, and indicated multiple stage II (partial-thickness of skin loss, presents as a shallow open ulcer or serum-filled blister) pressure ulcers.</p> <p>R3’s Wound Management Detail Reports dated 6/15/26, identified stage II pressure ulcer on the coccyx, stage II pressure ulcer on the gluteal fold, and stage II pressure ulcer on left buttock. Date</p> |                                                                  |  | F0641                                                                                             | <p>Continued from page 1</p> <p>corrected as appropriate.</p> <p>Pierz Villa will provide education for licensed nursing staff and clinical team on accurate identification, documentation, and coding of pressure injuries, including timely communication of changes in skin condition. MDS Coordinator will ensure supporting clinical documentation is reviewed prior to finalizing MDS assessment for residents with pressure injuries to support accurate coding.</p> <p>DON or designee will conduct weekly audits for 4 weeks, then monthly audits for 2 months, of residents with pressure injuries to ensure MDS accuracy. Audits will verify alignment between MDS coding and supporting clinical documentation. Any discrepancies identified during an audit will be immediately reviewed, corrected, and additional education will be provided as needed. A summary of the audit results will be reported and reviewed with the QA committee for further recommendations, and to determination of need for on-going monitoring.</p> <p>The Pierz Villa will be in compliance by September 10, 2026.</p> |                                              | 09/10/2026                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245286 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PIERZ VILLA INC  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>119 FAUST STREET SOUTHEAST , PIERZ, Minnesota, 56364 |                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                     |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                              | (X5)<br>COMPLETION<br>DATE |
| F0641<br>SS = D                                      | <p>Continued from page 2<br/>identified indicated 6/15/26.</p> <p>R3’s Wound Management Detail Report dated 6/23/26, identified a stage II pressure ulcer to the right buttock. Date identified indicated 6/23/26.</p> <p>R3’s Progress note dated 6/11/26, indicated R3 was admitted with blanchable redness to buttocks. The Progress Note was edited on 6/15 and indicated multiple pressure ulcers to coccyx and left and right buttocks.</p> <p>R3’s Progress Note dated 6/14/26, indicated nurse completed buttock care and noted an open area.</p> <p>R3’s admission MDS dated 6/18/26, indicated she was not at risk for developing pressure ulcers and indicated she had one or more unhealed pressure ulcers. The MDS identified three stage II pressure ulcers present on admission to the facility.</p> <p>R3’s Wound Management Detail Report dated 6/23/26, identified a stage II pressure ulcer on the right buttock.</p> <p>R3’s discharge MDS dated 6/29/26, identified Five stage II pressure ulcers present on admission.</p> <p>During interview on 7/23/26 at 11:29 a.m., registered nurse (RN)-A stated when completing the MDS, she reviewed the wound care notes and if there were questions, she would have interviewed staff. RN-A stated the wound documentation indicated R3’s pressure ulcers were present on admit. RN-A stated the pressure ulcers noted on R3’s hospital notes must have healed in the hospital.</p> <p>During interview on 7/23/26 at 11:29 a.m., the director of nursing (DON) stated when coding the MDS, RN-A should have reviewed the admission assessment.</p> |                                                                     |  | F0641                                                                                             |                                                                                                                          |                                              | 09/10/2026                 |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>PIERZ VILLA INC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                    |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>119 FAUST STREET SOUTHEAST , PIERZ, Minnesota, 56364 |                                                                                                                          |                                              |                            |
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| 20000                                               | <div>Initial Comments</div> <div>*****ATTENTION*****</div> <div>NH LICENSING CORRECTION ORDER</div> <div>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.</div> <div>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.</div> <div>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.</div> <div>INITIAL COMMENTS:</div> <div>On 7/22/26 through 7/23/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</div> <div>The following complaint was reviewed: H52863446C (3105982). The following order was issued as the</div> |                                                    |  | 20000                                                                                             |                                                                                                                          |                                              | 08/21/2026                 |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  | TITLE | (X6) DATE |
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| 20000                                               | <p>Continued from page 1<br/>result of an incidental finding (0550).</p> <p>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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>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.</p> |                                                    |  | 20000                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                              | 08/21/2026                 |
| 20550                                               | <p>Comprehensive Resident Assessment; Review</p> <p>CFR(s): MN Rule 4658.0400 Subp. 4</p> <p>Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                    |  | 20550                                                                                             | <p>Pierz Villa strives to ensure that resident assessments accurately reflect each resident's clinical condition and are supported by information contained in the resident's medical record.</p> <p>R3's MDS assessment and pressure-ulcer coding to be reviewed and corrected as applicable based on reconciliation of clinical documentation, and in accordance with the CMS requirements and facility policy to ensure accuracy. R3's care plan, treatment</p> |                                              | 09/10/2026                 |

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| 20550                                               | <p>Continued from page 2</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect facility acquired pressure ulcers for 1 of 1 resident (R3) reviewed with a pressure ulcer.</p> <p>Findings include:</p> <p>R3’s Face Sheet indicated she admitted to the facility 6/11/26. R3’s diagnoses included contact dermatitis, pressure ulcers of buttocks right and left, and pressure ulcer of sacral region.</p> <p>R3’s hospital Progress Notes dated 6/5/26, identified pressure injuries to right and left heels.</p> <p>R3’s Head to Toe Skin Assessment dated 6/11/26, identified blanchable redness to R3’s buttocks. The assessment indicated R3 did not have a pressure ulcer.</p> <p>R3’s care plan dated 6/11/26, identified a risk for pressure ulcers. The care plan was updated 6/15/26, and indicated multiple stage II (partial-thickness of skin loss, presents as a shallow open ulcer or serum-filled blister) pressure ulcers.</p> <p>R3’s Wound Management Detail Reports dated 6/15/26, identified stage II pressure ulcer on the coccyx, stage II pressure ulcer on the gluteal fold, and stage II pressure ulcer on left buttock. Date identified indicated 6/15/26.</p> <p>R3’s Wound Management Detail Report dated 6/23/26, identified a stage II pressure ulcer to the right buttock. Date identified indicated 6/23/26.</p> <p>R3’s Progress note dated 6/11/26, indicated R3 was admitted with blanchable redness to buttocks. The Progress Note was edited on 6/15 and indicated multiple pressure ulcers to coccyx and left and right buttocks.</p> <p>R3’s Progress Note dated 6/14/26, indicated nurse completed buttock care and noted an open area.</p> <p>R3’s admission MDS dated 6/18/26, indicated she was not at risk for developing pressure ulcers and indicated she had one or more unhealed pressure ulcers. The MDS identified three stage II pressure ulcers present on admission to the facility.</p> <p>R3’s Wound Management Detail Report dated</p> |                                                    |  | 20550                                                                                             | <p>Continued from page 2</p> <p>orders, and nursing interventions for review and revision as needed to reflect the current clinical condition.</p> <p>DON and MDS Coordinator to conduct a review of all residents with a current or recent pressure injury/ulcer, including those identified on admission, during a significant change in condition, or within the active MDS assessment period. Any discrepancies identified will be reviewed and corrected as appropriate.</p> <p>Pierz Villa will provide education for licensed nursing staff and clinical team on accurate identification, documentation, and coding of pressure injuries, including timely communication of changes in skin condition. MDS Coordinator will ensure supporting clinical documentation is reviewed prior to finalizing MDS assessment for residents with pressure injuries to support accurate coding.</p> <p>DON or designee will conduct weekly audits for 4 weeks, then monthly audits for 2 months, of residents with pressure injuries to ensure MDS accuracy. Audits will verify alignment between MDS coding and supporting clinical documentation. Any discrepancies identified during an audit will be immediately reviewed, corrected, and additional education will be provided as needed. A summary of the audit results will be reported and reviewed with the QA committee for further recommendations, and to determination of need for on-going monitoring.</p> <p>The Pierz Villa will be in compliance by September 10, 2026.</p> |                                              | 09/10/2026                 |

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| 20550                                               | <p>Continued from page 3</p> <p>6/23/26, identified a stage II pressure ulcer on the right buttock.</p> <p>R3’s discharge MDS dated 6/29/26, identified Five stage II pressure ulcers present on admission.</p> <p>During interview on 7/23/26 at 11:29 a.m., registered nurse (RN)-A stated when completing the MDS, she reviewed the wound care notes and if there were questions, she would have interviewed staff. RN-A stated the wound documentation indicated R3’s pressure ulcers were present on admit. RN-A stated the pressure ulcers noted on R3’s hospital notes must have healed in the hospital.</p> <p>During interview on 7/23/26 at 11:29 a.m., the director of nursing (DON) stated when coding the MDS, RN-A should have reviewed the admission assessment.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures related to completion and review of MDS for accuracy. The DON or designee could provide education to all MDS nurses on these policies and procedures. The DON or designee could conduct audits on MDS completed assessments and share the results with the Quality Assessment Performance Improvement (QAPI).</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> |                                                    |  | 20550                                                                                             |                                                                                                                          |                                              | 09/10/2026                 |